PRACTICE HANDBOOK

Suicide Bereavement Support Group Facilitation

Australian Government
Department of Health and Ageing

Lifeline Australia
“The friend who can be silent with us in a moment of despair or confusion, who can stay with us in an hour of grief and bereavement, who can tolerate not knowing — not healing — not curing — that is a friend who cares.”

Henri Nouwen
April 2009

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The views expressed in this publication are not necessarily those of the Commonwealth Department of Health & Ageing.

For information about this publication please contact Lifeline Australia on (02) 6215 9400 or national@lifeline.org.au or www.lifeline.org.au/find_help/suicide_prevention

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Preface

Lifeline Australia received funding from the Commonwealth Department of Health & Ageing under the National Suicide Prevention Strategy for a Suicide Bereavement Support Group Standards & Practice Project, 2007–2009. A small group of collaborative partners came together under this project to complete a number of objectives.

- **Objective 1**: Develop Standards & Guidelines
- **Objective 2**: Develop a Best Practice Handbook
- **Objective 3**: Develop Training for Facilitators
- **Objective 4**: Run Suicide Bereavement Support Groups based on 1, 2 & 3 above

This resource is a Practice Handbook for those who are facilitating or leading suicide bereavement support groups (SBSG). It is based on a set of standards, *Towards Good Practice: Standards & Guidelines for Suicide Bereavement Support Groups* (see Appendix 17), that were developed through wide consultation with people working with suicide bereavement support groups and with experts working in the field of Postvention. This resource aims to provide guidance and assistance for those developing and running SBSGs, as well as a framework for reviewing and evaluating current practices by those who operate groups.

The development of the *Standards & Guidelines for SBSGs and Practice Handbook for SBSG Facilitation* is based on existing research evidence and practice evidence available in the field. A separate literature review was undertaken and consultation with experienced SBSG facilitators provided a framework around which to develop these tools. This Handbook attempts to be a comprehensive resource and not to be a prescriptive guide.

The *Standards & Guidelines for SBSGs and Practice Handbook for SBSG Facilitation* are components of a larger project which also supported the development of a comprehensive training for SBSG facilitators. The competency based training was developed under the Australia Quality Training Framework (AQTF), a national set of standards which assures nationally consistent, high-quality training & assessment services for clients of Australia’s vocational education & training system.

In order to develop a SBSG Facilitator training package, Lifeline Australia worked with the Community Services & Health Industry Skills Council (CSHISC) to develop two nationally recognised training competencies in the new Community Services Training Package, which was released December 2008.

The two competencies that have been created are:
- *Provide support and care relating to loss and grief* (CHCCS426A)
- *Provide support and care relating to suicide bereavement* (CHCCS417A)

The already existing competencies below also guided the development of SBSG facilitator training:
- *Facilitate groups for individual outcomes* (CCHICS405A), and
- *Use targeted communication skills to build relationships* (CHCCOM403A)

This SBSG Facilitator Practice Handbook was developed alongside the Standards, Guidelines and Facilitator Training. It is one resource to assist those involved with suicide bereavement service provision. It is recommended that facilitators seek training, supervision and support in order to undertake this important role.
Foreword

As CEO of Lifeline Australia I am very proud of the collaborative work that has been done to assemble this valuable resource. Lifeline provides suicide prevention to the community and has done so for 46 years. Supporting those bereaved by suicide is an integral part of our work and we will continue to be guided by best practice to provide quality assured services.

By funding this Project, the Commonwealth has created a world first opportunity, where stakeholders across the sector, across the nation, have come together and developed Standards, Guidelines and a best practice Handbook to support those working with the bereaved by suicide. Training for facilitators based on these resources ensures that suicide bereavement support group members are supported in the best possible way.

Lifeline is grateful to the many individuals and organisations whose generosity and expertise have contributed to the development and refinement of this Practice Handbook. It is a resource that will guide those starting up a new group and support those continuing to run their already existing groups. It provides an enormous collection of information and guidance across a wide range of issues that I am sure will equip facilitators along with the training, to be confident and competent in supporting people impacted by the devastating loss of their loved one to suicide.

I enthusiastically endorse this Practice Handbook and encourage all facilitators to join the community of practice that has developed it. I am reminded of the quote from Sir Isaac Newton “If I have seen further it is by standing on the shoulders of giants”. I wish you ‘clear vision’ and all the best in running your support groups and trust that these resources can provide guidance for the much needed, rewarding work you do in your community.

Dawn O’Neil, AM
CEO
Lifeline Australia
Statement of Support & Endorsement

As Director of AISRAP, a WHO Collaborating Centre for Research & Training in Suicide Prevention, and member of the Australian Suicide Prevention Advisory Council I would like to congratulate Lifeline Australia and the collaborative partners who have come together to develop this comprehensive resource. During my tenure as President of the International Association of Suicide Prevention (IASP) I supported the elevation of Suicide Bereavement (Postvention) within the profile of suicide prevention policy and activities internationally. This included assembling an IASP Postvention Taskforce and including a Postvention focused day at the IASP Conference.

However, despite admirable measures undertaken by IASP and national organizations around the world, programs of support for the suicide bereaved are still sadly lacking and these are often seen as the poor cousin of prevention.

Research that has investigated the nature of grief, its associated morbidity and the needs of the suicide bereaved has confirmed the necessity for comprehensive and accessible services. While there may be a dearth of evidence for suicide bereavement support groups, what we do know is that as a humane society we need to provide support for those impacted by such a devastating loss. This support should be guided by Standards and Best Practice to ensure the health and safety of participants.

I fully endorse this Practice Handbook and encourage all those involved with operating Suicide Bereavement Support Groups to join this community of practice and take advantage of this valuable resource. I wish you every success with the challenging work you undertake to support people bereaved by suicide.

Diego De Leo, MD, PhD, DSc, FRANZCP
Professor of Psychiatry,
Director, Australian Institute for Suicide Research and Prevention,
National Centre of Excellence in Suicide Prevention,
WHO Collaborating Centre for Research and Training in Suicide Prevention, and
Life Promotion Clinic
Griffith University, Queensland
Acknowledgements

This Practice Handbook is a component of the Commonwealth's Lifeline Suicide Bereavement Support Group (SBSG) Standards and Practice Project. It has been developed as a collaborative effort of many individuals and organisations. Their generous contributions of knowledge, expertise and time are acknowledged here with deep appreciation for their assistance in developing a tool which will benefit those who provide support for people bereaved by suicide. The Handbook may also be relevant for those who provide bereavement support to other than those bereaved by suicide.

Lifeline Australia would like to gratefully acknowledge the contribution made by the Project Expert Reference Group that has devoted considerable time and expertise in overseeing the project and this Practice Handbook: Julie Aganoff, Lifeline Brisbane; Margaret Appleby, Rose Education Pty Ltd; Eve Barratt, Lifeline South East SA; Graham Clue and Helen Lindner, Australian Psychological Society; Jill Fisher, StandBy (Suicide Bereavement) Response Service, United Synergies; Sharon Hillman, ARBOR, Ministerial Council for Suicide Prevention, WA; Roslyn Lockhart, Congress of Aboriginal and Torres Strait Islander Nurses; Jane Mowll, Dept of Forensic Medicine, NSW Health; Jon Stebbins, Compassionate Friends VIC; Jon Spiteri and Vicki Katsifis, Multicultural Mental Health Australia; Rod Hurley, Commonwealth Department of Health & Ageing.

Special recognition and gratitude also needs to be extended to the Training Team who developed and provided nationally accredited, competency based training to two sets of Facilitators. This highly skilled and experienced team worked collaboratively for a year to devise and fine tune the training materials. The Team consisted of: Linda Espie (Jesuit Social Services, Support After Suicide program), Jill Fisher, Jane Mowll, Dr Jon Stebbins, Wendy Raikes (Raikes Consulting) and Susan Beaton (Lifeline Australia). Recognition and thanks also to Jane Mowll and Kate Friis, senior forensic counsellors and social workers with the Department of Forensic Medicine who provided high quality external group supervision to trainee Facilitators while they ran their trial SBSGs.

Participants who attended the May 2007 National Postvention Conference pre-conference workshop “How To – Support Groups – Models & Best Practice Guidelines” also contributed to the evolution of this Handbook and deserve recognition and thanks. Also, experienced facilitators from across Australia who attended the SBSG Facilitators Forum September 2007 contributed greatly to the progress of this Handbook. Particular recognition goes to the following organizations for their co-operation and generous sharing of their resources and knowledge: NSW Department of Forensic Medicine, Forensic Counselling Service and Support After Suicide Group facilitators; Jesuit Social Services, Support After Suicide program; Corporate Diagnostics; United Synergies and StandBy (Suicide Bereavement) Response Service; Compassionate Friends Victoria; Dr Diana Sands, Director Bereaved by Suicide Service; Australian Psychological Society; American Foundation for Suicide Prevention Survivor Initiatives Director Joanne Harpel; American Association for Suicidology Survivor Division Chair and Co-Chair iASP Postvention Taskforce, Michelle Linn-Gust; HEARTBEAT Grief Support Following Suicide founder LaRita Archibald; Baton Rouge Crisis Intervention Center, Executive Director, Frank Campbell; iASP Postvention Task Force, Co-Chair, Karl Andriessen.

We would like to gratefully acknowledge the comprehensive work done by Corporate Diagnostics and United Synergies in undertaking the Commonwealth funded National Activities on Suicide Bereavement project in 2006. That project’s outcomes, including the Draft Guidelines and Standards for Suicide Bereavement Support Groups, have been foundational in guiding the development of this project.
Acknowledgements

Appreciation needs to be extended to the eight Lifeline Centres who had the courage to participate in this trial. Our gratitude also to the trainee Facilitators who participated in the newly developed nationally accredited, competency based training, undertook copious assessment tasks and ran trial groups out of their Centres during 2008. We also thank our most vulnerable project members, the people bereaved in the community who trusted Lifeline to provide a support group and safe place to gather with others bereaved by suicide.

The project is indebted to ARTD Consultants – Strategy & Evaluation, for their professional and conscientious external evaluation which has supported and informed the project from the outset.

Wendy Raikes (Raikes Consulting) has been consultant researcher and writer for the entire project; her breadth of knowledge and skills, dedication and attention to detail have been of immeasurable benefit and we extend our most sincere gratitude to her.

We are grateful to the Commonwealth Department of Health and Ageing for funding provided under the National Suicide Prevention Strategy for the development of this Handbook and the overall Project. The Practice Handbook is a component of Lifeline's SBSG Standards & Practice Project January 2007 – June 2009.
### Definitions and Glossary

In this Handbook many of the following terms and definitions are used in the context of suicide bereavement.

<table>
<thead>
<tr>
<th>Term</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>Adjustment</td>
<td>The process of adjusting to new conditions.</td>
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<tr>
<td>Administrative supervision</td>
<td>A process concerned with the quality of the practice by the person being supervised in respect of professional standard and ethics.</td>
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<tr>
<td>Attempted suicide</td>
<td>Self-inflicted harm where death does not occur but the intention of the person was to die.</td>
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<tr>
<td>Auspice body</td>
<td>A government or non-government organisation that takes legal and ethical responsibility for group functioning, maintenance and support; manages government funded programs and is legally responsible for implementation and reporting requirements.</td>
</tr>
<tr>
<td>Bereavement</td>
<td>The period of grief after a loss (usually the death of a loved one).</td>
</tr>
<tr>
<td>Closed group</td>
<td>Generally a time limited group where the same members attend for a specified time period.</td>
</tr>
<tr>
<td>Complicated/Complex grief</td>
<td>Grief that is complicated by adjustment disorders e.g. depression, anxiety.</td>
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<tr>
<td>Cultural safety</td>
<td>An environment, which is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need.</td>
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<tr>
<td>Debriefing</td>
<td>A structured meeting after an event to discuss what has happened, going over an experience or set of actions, to achieve some sort of order or meaning concerning them.</td>
</tr>
<tr>
<td>Defusing</td>
<td>A shortened version of a debriefing process, close as possible to an event or incident.</td>
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<tr>
<td>Disenfranchised grief</td>
<td>A grief that is not openly acknowledged, socially supported or publicly observed.</td>
</tr>
<tr>
<td>Duty of care</td>
<td>A duty to take reasonable care of a person. A support group owes a duty of care to anyone who is reasonably likely to be affected by the group’s activities.</td>
</tr>
<tr>
<td>Empathy</td>
<td>The act of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another without necessarily personally holding the same feelings, thoughts or experience.</td>
</tr>
<tr>
<td>Facilitators of a support group</td>
<td>People who lead a support group.</td>
</tr>
<tr>
<td>Grief</td>
<td>An emotional response to the perception of loss, which has effects at the physical, spiritual, behavioural, cognitive, psychological and social levels.</td>
</tr>
<tr>
<td>Integration of grief</td>
<td>Incorporating grief as an ongoing part of the bereaved person’s life.</td>
</tr>
<tr>
<td>Loss</td>
<td>Produced by an incident which is perceived to be negative by those involved and results in long-term change.</td>
</tr>
<tr>
<td>Members of a support group</td>
<td>People who participate in a support group.</td>
</tr>
<tr>
<td>Mourning</td>
<td>The process by which people adapt to the death of a loved one. Mourning is influenced by cultural customs, rituals and by societal expectations of coping.</td>
</tr>
<tr>
<td>Term</td>
<td>Explanation</td>
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<tr>
<td>Mutual help support group</td>
<td>A support group established and run by people who have been bereaved by suicide, sometimes called a self-help support group.</td>
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<tr>
<td>Normalisation</td>
<td>A process which aims to identify behaviours and ideas as normal.</td>
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<tr>
<td>Open Group</td>
<td>Generally an ongoing group where the membership is fluid.</td>
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<tr>
<td>Peer review</td>
<td>Review of work or performance by other people in the same field in order to maintain or enhance the quality of the work or performance.</td>
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<tr>
<td>Psycho-educational support group</td>
<td>A support group which aims to educate and provide empathy and support to cope with emotional, cognitive, behavioural and social aspects of suicide bereavement.</td>
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<tr>
<td>Resilience</td>
<td>Capacities within a person that promote positive outcomes, such as mental health and wellbeing, and provide protection from factors that might otherwise place that person at risk of suicide. Resilience is often described as “the ability to bounce back from adversity”.</td>
</tr>
<tr>
<td>Risk factors</td>
<td>Factors such as biological, psychological, social and cultural agents that are associated with suicide/suicide ideation.</td>
</tr>
<tr>
<td>Self-care</td>
<td>Refers to decisions and actions that an individual can take to look after oneself in all aspects of living, and cope with a situation or to improve his or her health and wellbeing.</td>
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<tr>
<td>Self-harm</td>
<td>Self inflicted harm where death does not occur and the intention may or may not have been to die.</td>
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<tr>
<td>Staff</td>
<td>Includes paid employees and volunteers.</td>
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<tr>
<td>Suicidal behaviour</td>
<td>Acts such as suicide and attempted suicide.</td>
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<tr>
<td>Suicidal ideation/thoughts</td>
<td>Thoughts about, or plans for, taking one's own life that may or may not lead to attempting or completing suicide.</td>
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<tr>
<td>Suicide</td>
<td>Death as a result of self-inflicted harm where the intention was to die.</td>
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<tr>
<td>Suicide Postvention</td>
<td>Interventions to support and assist the bereaved after a suicide has occurred.</td>
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<tr>
<td>Supervision</td>
<td>Supervision provides a structured, monitored environment that supports volunteers and staff in skills and knowledge development with both practice and ethical considerations and, in turn contributes to quality service provision.</td>
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<tr>
<td>Survivor</td>
<td>A term that is used to denote a person bereaved by suicide. A survivor of suicide is a family member or friend of a person who died by suicide. The term ‘survivor’ is often used in the international literature. In Australia the term ‘suicide bereaved’ is generally used in preference to survivor.</td>
</tr>
<tr>
<td>Trauma</td>
<td>An experience that is emotionally painful, distressful, or shocking, which often results in lasting mental and physical effects.</td>
</tr>
<tr>
<td>Traumatisation</td>
<td>To be subjected to psychological trauma.</td>
</tr>
<tr>
<td>Vicarious Traumatisation</td>
<td>Impact of being a secondary witness to another's sharing of a traumatic event.</td>
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1. Introduction

Evidence (Beautrais, 2004; Campbell, 1997; Campbell, Cataldie, McIntosh & Millet, 2004; Davis & Hinger, 2005; Hatton & Valente, 1981; Hopmeyer & Werk, 1993; Murphy, Johnson & Lohan, 2003; Parrish & Tunkle, 2005; Pietila, 2002) from research has shown that people bereaved by suicide have different emotional experiences of grief and a potentially higher risk of poor grief outcomes than other bereaved people. Those bereaved by suicide commonly experience feelings of rejection, abandonment, blame, anger, helplessness, remorse, guilt, responsibility, stigma, isolation, shame and embarrassment. The need to understand why and the search for motive of the suicide commonly preoccupy their thoughts.

In 1972 Dr Edwin Shneidman said that “Postvention is prevention for the next generation”. Research has demonstrated that people bereaved by suicide are often themselves at increased risk of suicide. Creating opportunities for support may ameliorate this risk and increase the mental health, well being and integration of grief required to cope with the suicide death of a loved one.

Research has also investigated the effectiveness of suicide bereavement support groups. There is a wide range of groups that operate in Australia and around the world that provide support to people bereaved by suicide, with varying structures, membership, and purposes. Some mutual-help groups are led by a person who has been bereaved by suicide while other groups are led by a professional, such as a grief counsellor. Some groups are ongoing and open for participation by members at times that they need support and other groups run for a limited number of weeks with a specific program each week. Some groups have specific target audiences, such as children or adolescents, and other groups may target adults. The common purpose is that groups wish to help those bereaved by suicide by providing a safe, tolerant and empathic environment where bereaved people can be with others who have had similar experiences, to share each other’s loss and grief, and to receive and provide mutual support. A support group assists in normalising experiences, reduces the stigma often associated with a suicide death, educates people about the grieving process, and assists them to adjust to living without their person who died. A support group also works to reduce the sense of isolation felt so often by those bereaved by suicide. Attendance at group meetings may help build inner strength, develop new coping skills and strengthen the capacity of the group to help one another.

In summary, Suicide Bereavement Support Groups may provide: (WHO, 2008)

- A sense of community and support
- An empathic environment and gives a sense of being understood
- The hope that ‘normality’ can be reached eventually
- Shared experiences in suicide bereavement, such as difficult anniversaries or special occasions
- Opportunities to learn new ways of approaching every day functioning
- A sounding board to discuss fears and concerns
- A setting where the expression of grief may be shared, confidentiality is observed, and compassion and support are offered
- Information and support about suicide and suicide bereavement.

1.1 Handbook aim

This resource is a Practice Handbook for those who facilitate or lead suicide bereavement support groups (SBSG). It is based on a set of standards, Towards Good Practice: Standards & Guidelines for Suicide Bereavement Support Groups (see Appendix 17). This resource aims to provide
guidance and assistance for those developing and operating SBSGs, as well as a framework for reviewing and evaluating current practices by those who operate existing groups. This Handbook aims to be a comprehensive resource and not a prescriptive guide; it is also not a substitute for training and supervision but a complement to it.

1.2 Suicide bereavement, loss, grief and trauma

When facilitating SBSGs, it is important to have knowledge about suicide bereavement, loss, grief and trauma. There are many sources of information about this, including training courses, academic literature, and other resources (refer Section 13 Resources). A good understanding of the issues is crucial for SBSG facilitators and the following information provides a summary of current knowledge.

There are similarities in features of the grief patterns that people bereaved by suicide face, although not all people bereaved by suicide may experience all the grief features or at the same intensity. Researchers (Parrish & Tunkle, 2005; Jordan & McMenamy, 2004; Barlow & Morrison, 2002; Clark, 2001; Jordan, 2001; Dunne, 1992b; Hatton & Valente, 1981; Beautrais, 2004 — refer to Appendix 16 for full references) identify a number of common features. The following is from McIntosh & Hubbard (2007):

1.2.1.1 Common factors in death by suicide

- **Suicide death is usually sudden and unexpected:** The suddenness and unexpectedness does not permit people bereaved by suicide to have anticipated the death or to have prepared themselves for its occurrence. Both of these factors are associated with difficult, sometimes complicated, bereavement. Bereaved people nearly always seem unprepared even though there are often, but not always, signs of suicide.

- **Death by suicide often leaves unfinished, unresolvable issues:** The sudden, unexpected nature of most suicide deaths provide no time or opportunity for the bereaved person to work on their unfinished relationship with the one who died.

- **Death by suicide is often violent:** The violence of the death and sometimes the death scene itself may produce difficulties for bereaved persons. The violent death may produce intensely disturbing, even intrusive images for bereaved persons in association with their memory and thoughts about the death. This may produce anger toward the lost person and/or additional distress about the deceased person’s level of suffering.

- **Suicide often occurs in systems already experiencing stress:** A suicide death often occurs in the context of multiple stressors in the lives of the person who died. Those people bereaved often share environments as well as stressors. A history of depression in particular may produce or accompany such multiple stress circumstances for the eventual suicide.

- **Death by suicide may compromise usual mourning rituals:** Feelings of shame, stigma, and even guilt that suicide bereaved people often experience may result in alterations and even elimination of normal rituals and behaviours associated with grief and bereavement. The family may decide to have private ceremonies or other burial or funeral arrangements that differ from those they would have chosen in another mode of death. Most importantly, this may deprive bereaved people of the important support and comfort afforded by such rituals and ceremonies.

- **Death by suicide always involves a Coronial investigation:** Deaths suspected as a suicide are always the subject of a coronial investigation and the death is not registered until investigations are complete and the cause of death assigned. Refer to Appendix 14 for more information on the Coronial Investigation process (and Section 13.6).
1.2.2 Common elements of grief of people bereaved by suicide

- **Shock, numbness and denial**: People bereaved by suicide, like those bereaved by other deaths, may initially feel shock and numbness in response to the suicide. The death may even seem unreal. In some cases, even beyond initial reactions, bereaved persons may deny the death or more often deny the mode of death as suicide, sometimes vehemently and for long periods of time.

- **Search for a reason for the suicide, why?**: One of the most commonly observed aspects of suicide bereavement, perhaps in both intensity and duration, is not just questioning reasons for the death, but a gnawing need to understand this suicide, even all suicides, to answer the question ‘Why?’.

- **Some suicide bereaved people find that they need to**:
  - reaffirm or reconstruct a world of meaning that has been challenged by their loss, and/or
  - redefine a continued bond with their person who died, and/or
  - restore a sense of self coherence that has been disrupted by their loss (Neimeyer, 2006).

- **Shame, guilt, responsibility, blaming, relief and scapegoating**: Among the social reactions suicide bereaved people often experience, are feelings of shame and stigma. Another generally observed aspect often includes feelings of guilt and responsibility for the death, frequently at levels far beyond anything reasonable – guilt for what they did, what they did not do, what they could have done but didn’t, etc. Suicide bereaved people often blame others as well for the death (the person who died, mental health professionals, others), sometimes even scapegoating one or more people, who are held almost entirely responsible for the suicide. At other times some suicide bereaved people may feel relief, particularly if there has been a long period of mental illness. The feelings of relief may be accompanied by feelings of guilt about the relief, and this can lead to conflicting and distressing emotional states.

- **Anger**: People bereaved by suicide may feel anger toward themself, others, the person who died. This anger is often accompanied by the feelings of and placing of responsibility and blame or guilt. The guilt toward the deceased may be denied and may be a factor in blaming.

- **Loneliness, social isolation and social supports affected**: People bereaved by suicide often feel lonely and socially isolated, both from possible lack of contact with others and the feeling that no one understands their experience and how they feel, or that they are the only one who feels as they do (they feel different). Some of the social isolation may derive from the withdrawal of others for many possible reasons (discomfort, uncertainty about how to behave, etc.) as well as the withdrawal on the part of the bereaved person themselves due to their feelings of shame, stigma, or guilt.

- **Stigma**: Despite changes in the laws of the State and church which no longer deem suicide to be a crime or a sin, there remains considerable stigma associated with suicide. General community lack of awareness, understanding and education regarding suicide and the experience of suicide bereavement continue to contribute to this stigma. Someone bereaved by suicide may experience real stigma where they are socially alienated by friends, colleagues, etc., or perceived stigma where they imagine that people don’t want to associate with them so they avoid social settings. Stigma is a condition often experienced by people bereaved by suicide which is not necessarily experienced by people bereaved by other circumstances.

- **Difficulty trusting others, feeling abandoned, family relations are often affected, sometimes negatively**: The loss of the person, sometime perceived as an elected abandonment, may affect the bereaved person’s ability or willingness to trust others (the person who died was trusted and they chose to die). Sometimes over-protectiveness of remaining loved ones may occur as well (especially in the case of the death of a child). Family relations and communication may be either strengthened by the loss or weakened and strained by it (scapegoating of other family members is one example).
• **Depression and heightened suicide risk:** In response to the suicide of a person, bereaved people may become clinically depressed themselves; not only have they experienced the loss of a significant other to suicide, they may share the environment and stressors that influenced the person’s death by suicide. A number of clinicians and researchers have discussed possible heightened suicide risk on the part of bereaved people themselves (certainly this would be reasonable given the relationship of suicide to depression).

• **Integration, Not Resolution of the Loss:** The metaphor of ‘get over it’ is not very helpful or accurate. People who are profoundly impacted by a suicide do not ‘resolve’ this type of loss. Rather they integrate the experience into their life and learn to carry their grief with them as part of their identity.

### 1.2.3 Gender differences in grief and coping strategies

There appears to be gender differences in the experience of grief and coping strategies (Davis & Hinger, 2005; Grad et al., 2004; Heiney et al., 2003; Hopmeyer & Werk, 1993; Jordan & McMenamy, 2004; Murphy, Johnson & Weber, 2002). An instrumental orientation to coping is more characteristic of males and hence groups may be less effective for people with such coping orientations as group processes include self-disclosure and sharing of feelings. Males may be more reliant on practical help and getting back to routine and, in support groups, may prefer items related to problem solving, coping and information gathering. Some support groups find that offering seminars, information sessions and walking groups are a way of attracting male members and satisfying their needs.

### 1.2.4 How does this impact SBSG facilitators?

Recognising the above may help guide group facilitators to work with people bereaved by suicide in the following ways: (Stebbins & Stebbins, 2000, used with permission)

- Bereaved people need clear, simple structures as they move from chaos to order. Meetings that are simply structured and follow the same format may help meet this need.
- A non-judgemental atmosphere is essential, particularly with self-blame and anger directed at a range of people such as family, friends, and professionals. Non-judgemental listening helps to develop balanced, realistic perspectives.
- Time to express needs is required. The person’s story is painful and unique to them. Long pauses, hesitancy and clouded thinking can be expected. Slowing the telling of stories may be helpful.
- Newly bereaved people require the opportunity to express feelings, thoughts and experiences and to hear those of others. This helps to normalise their experiences. Newly bereaved people may require some time to observe and be silent before they feel ready to start participating. Those who have been attending a support group for some time may provide hope to the newly bereaved; the well known and highly regarded postvention specialist Frank Campbell from Baton Rouge Louisiana refers to this as ‘the instillation of hope’.
- Group members, as they progress through their journey, often gain most from the networks that they develop.
- The group facilitator’s task is to develop an atmosphere of care and support, where stories can be told, listened to and clarified. Through this process, most members will move towards integrating their loss and re-growth.
2. Setting Up a Support Group

2.1 The purpose and aims of the support group facilitator

The type of “learning” that the facilitator aims to foster in a SbSG is learning drawn from the members’ own knowledge and experiences and by hearing others do the same. The principles of adult learning are generally used by facilitators in these groups. This type of learning builds group members’ skills and their confidence to manage their grief, solve problems, and accomplish their goals in daily functioning. The goal is for the participants to achieve greater understanding and to have some new strategies for dealing with suicide bereavement issues, as opposed to ensuring participants gain a particular amount of knowledge. It is important to accept that according to this model of support the facilitator is not positioned as a holder of ‘superior’ knowledge whose job it is to ‘deliver’ this knowledge to less knowledgeable others. Rather, the facilitator’s purpose is to create an environment that allows the group members to draw on their own experiences and knowledge to further their own learning in a collaborative and supportive environment.

2.2 Considerations for a support group facilitator

The World Health Organisation (2008) has identified a number of considerations in setting up a SBSG. These are a series of questions that a person who wishes to set up a group might ask:

- Who will serve as facilitator of the group? If you are one who has been bereaved will you be a lead facilitator or will you seek professional help to support and conduct the meetings? In the early stages of the group, a member of a helping profession may assist in setting up the group. It may be that a mental health professional or other suitably qualified professional who has a special interest and skill in working with people bereaved by suicide will want to start a support group where clients can benefit from the group process. Or, a person bereaved by suicide may want to join forces with a mental health professional to start a group where the experience of each can contribute to its success. Research (Farberow, 1992 and Wilson & Clark, 2004) has shown that suicide bereaved facilitators acted as a role model and provided hope, whereas mental health professionals were a source of safety, security, information and education.

- Who will be the co-facilitator? Is the co-facilitator committed? In order to reduce burnout, to debrief each other and to assist in situations of illness, at least two or three facilitators are considered necessary. If another facilitator is not available, perhaps you may consider being a support person rather than offer a support group. Co-facilitators can share the workload of tasks involved in setting up, promoting and maintaining a group. Co-facilitators are important to be able to address individual group member issues whilst simultaneously addressing whole of group needs e.g. suicidality of an individual member.

- Are you at a stage in your grieving that enables you to put the necessary energy into setting up the group? In the early stages of grief people’s energies may be needed just to survive on a day-to-day basis. Those who are further along the grieving process, i.e. one to a few years, will have more energy, will likely have made some progress in regaining a purpose and meaning in life, and probably have ‘integrated’ the loss of their loved one or friend enough to be able to reach out to help others. (WHO 2008).

- If you are a bereaved person and intend to be closely involved in facilitating the group, do you have the support of family members? They may not wish to be part of the group but if they are supportive of your need to form a group this will assist you.

- Do you feel a commitment to help others in the same situation?
• Do you feel the commitment to sustain a group over a period of time? There is a responsibility that goes with the formation of the group; once started, it will need to be sustained to fulfil community expectations.

• Do you have experience — possibly from a work situation, committees or group work — or organisational skills that can help you to get started? Skills in facilitating and working with groups are also useful. You should not hesitate to talk to professionals in your community about ways of obtaining additional skills or assistance. Once the group has been formed, it will have a pool of skills to draw on so that its members can take on the roles identified for the group to function effectively. Section 4.1 Selecting group facilitators outlines the key skills required for support group facilitators.

• What kind of bereavement support groups already exist in your local community? You can check likely sources of information by reading local newspapers, talking to your doctor, asking at the community health centre, scanning community notice boards, or visiting your local library. What has been the history or success of these groups? What have the leaders of these groups learned about what works and what does not?

• Is there an organisation in the community that could serve as an umbrella organisation or auspicing body for your group? The SbSG should be seen as non-religious, as a religious emphasis may be a discouragement for some individuals. If you are able to operate under a larger structure it will assist in sustaining the group. If that larger organisation also provides access to referral services, that is an additional bonus. An agreement will need to be reached with the umbrella organisation that sets out mutually approved aims and objectives for the group. The advantages and disadvantages of auspicing body are presented below in Table 1 and further discussion is found in Section 2.4.1 Auspice bodies.

• If you haven’t already got a mental health professional involved, should you consider their involvement? The professional might be involved, for instance, for consultation and/or supervision, for evaluation of members, to consider suitability of applicants, to determine psychiatric symptoms, to provide advice and recommendations for hospitalisation, to provide referrals for professional care, to determine progress or burnout, or to help in evaluating progress. (WHO 2008).

• How will you access regular debriefing, support and supervision? A group facilitator will need to ensure that self-care strategies are in place and maintained.

Other considerations might be: (Stebbins & Stebbins, 2000, used with permission):

• What type of group will you establish? Will it be ongoing or for a fixed term? Will it be structured or informal? How often will it meet? Who will be the members of the group, for example, age, gender, relationship to the person who died, cultural background, etc.? A discussion of different types of support groups is made in Section 3.1.1 Types of support groups.

• What do you know about grief and suicide? What do you know about group processes and facilitation? What do you know about health professionals and referrals? Refer to Section 1.2 Suicide bereavement, loss, grief and trauma and Section 5 The SbSG Meeting and Section 2.4.7 Referral pathways and community networking for further discussion.

• What skills do you have in facilitation, group leadership, communication, team management, marketing and networking? Section 6.1 Facilitation skills, Section 6 Facilitating the group and Section 2.4.5 Marketing, publicity, media and promotion provide more details.
2.3 Aims, objectives, values of the SBSG

SBSGs need a clear statement of purpose or vision in order to function effectively and set the direction. A set of objectives is also useful to describe how the purpose is achieved.

An example of aim and objectives from the Heartbeat Guidelines follows. Heartbeat chapters run suicide bereavement support groups in many parts of the USA heartbeatsurvivorsaftersuicide.org/index.shtml.

FOR THE PURPOSE OF: Resolving the grief for the cause of the death in order to achieve healthy resolution of grief for the loss

HEARTBEAT is an acronym that defines the healing philosophy

H healthy coping techniques through
E empathy and understanding reinforced by
A acceptance without judgment and affirmation of self-worth
R resolution of conflict and reinvestment in life
T truth…responsibility for this death must be allowed to rest with the one who made the choice and by
B being a resource to new survivors,
E effecting public prevention education and
A acknowledgement of suicide as a preventable health problem of considerable proportion within our community;
T transforming our grief energy into positive action that will diminish the number of these deaths.

Archibald, 2003 (used with permission)

Another example of an aim is:

‘To provide support to people who have been bereaved by suicide by providing a safe environment for them to share their grief with others who have also been bereaved by suicide.’ (Corporate Diagnostics, 2006, used with permission).

Another group states the objectives of their monthly meetings as: (NSW Department of Forensic Medicine, Support After Suicide Group, used with permission)

‘To provide an “open” support group that allows the bereaved to attend as they choose with no limits on the number of times a person may attend.

To meet at the same venue, at the same time of each month in a community venue.

To create an environment that is supportive of people talking about their feelings and reactions and also about the person who has died by suicide, in order to reduce isolation and normalise experiences.

To provide professional facilitation of the meeting to ensure that the environment is appropriately supportive for the safe expression of grief reactions and associated emotions.’
2.4 Organisation and management

2.4.1 Auspice bodies

An auspice body may be a government or non-government organisation that takes legal and ethical responsibility for group functioning, maintenance and support; manages government funded programs and is legally responsible for implementation and reporting requirements. They have in place adequate infrastructure including:

- effective management, either through management committees or other management structures
- good policy and procedural frameworks, including occupational health and safety, and risk assessment and management
- regular support, training and professional supervision for staff
- codes of ethics/conduct for staff and management that ensure the integrity of service delivery, particularly in relation to honesty, respect, confidentiality, safety, duty of care and recognition of consumer rights.

The auspice body may also be responsible for:

- the necessary infrastructure to facilitate service delivery, including suitable premises, appropriate access, etc;
- implementing policies, procedures and structures to support service delivery and the implementation of good practice
- taking reasonable care to protect staff, volunteers, and support group members
- ensuring that public liability and other necessary insurance covers are in place.

Table 1: Some considerations regarding an auspicing body

<table>
<thead>
<tr>
<th>Considerations</th>
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</thead>
<tbody>
<tr>
<td>Access to organisational resources such as administrative support and meeting space</td>
</tr>
<tr>
<td>Risks managed – e.g. potentially covered for Public Liability Insurance</td>
</tr>
<tr>
<td>Governance and accountability structures provided</td>
</tr>
<tr>
<td>Access to supervision and debriefing</td>
</tr>
<tr>
<td>Stronger proposals for funding, sponsorship</td>
</tr>
<tr>
<td>Existing presence in the community therefore offering credibility, broader promotion opportunities and knowledge of potential referrals</td>
</tr>
<tr>
<td>Time taken in liaising with corporate requirements</td>
</tr>
<tr>
<td>Reporting requirements</td>
</tr>
<tr>
<td>Potential restriction of activities</td>
</tr>
</tbody>
</table>

2.4.2 Incorporation

Some groups may consider incorporation as a legal entity. Alternatively, an auspicing body may be incorporated. If not auspiced, becoming an incorporated association may benefit members and protect them from debts and liabilities of the group. It allows a group to:

- continue regardless of changes to membership
- accept gifts and bequests
- buy and sell property
• enter into enforceable contracts
• sue or be sued
• apply for Government grants.

Incorporated associations should be non-profit organisations. This means that any profits made should be used to further the objectives of the association, not provide personal gain for its members.

The state Department of Fair Trading (or equivalent) will provide information on how to become an incorporated association.

To receive tax deductible gifts, an entity must be a deductible gift recipient (DGR). For more details refer to the Australian Taxation Office website: www.ato.gov.au/nonprofit/content.asp?doc=/content/66281.htm&page=1&pc=&mnu=28533&mfp=001/004&st=&cy=

2.4.3 Sponsorship/funding

SBSGs can save a lot of time, effort and money if they can find a good sponsor, or auspicing body. Such bodies might be health agencies, community agencies, funeral directors, church organisations, suicide prevention centres or other non-profit organisations. These types of organisations may assist with direct funding, meeting space, utilities (water, electricity), catering, enquiry services, office administration, publicity in newsletters, broader promotion, mail outs and other administrative support.

Groups may also look for sponsors for specific services. For example, businesses may donate or provide a discount for group activities such as newsletters and promotional brochures.

2.4.4 Legislation

Groups should consider the legislation that they need to abide by.

Legislation may include (this is not an exhaustive list):
• equal opportunity legislation
• discrimination legislation
• child protection legislation
• support groups providing services to children or young people will have to meet legal requirements regarding working with young people security checks
• confidentiality and privacy legislation (with exceptions for danger/threat to life)
• occupational health and safety legislation.

Groups leaders will need to monitor legislative developments that may apply to their practice. An auspice agency will usually have awareness of these requirements.

2.4.5 Marketing, publicity, media and promotion

Marketing, publicity and promotion are important so the SBSG can advise those bereaved by suicide as well as service providers about its existence. Such strategies are likely to be ongoing and may need constant renewal and refreshment.

Ideas for publicity and promotion include:
• Submit information to the free community announcements on radio and TV
• Provide stories/media release for the free newspapers, for example, in association with World Suicide Prevention Day 10 September
• Provide brochures to organisations such as hospitals, police chaplain, mortuaries, ambulance, funeral directors, community health services, general practitioners, clergy, community agencies and counselling services
• Include notices in community newsletters and newspapers (there is often a free Community Notices section)
• Liaise with the Coroner’s Office to ask how you could advise families of those who died by suicide about the SbSG
• Notify mental health services
• Get listed in your local government’s community services directory
• List in the Yellow Pages under Suicide, Grief or Support Groups
• Participate in public memorial events
• Participate in Library Displays
• Attend community events
• Ask for a link on other websites to the group’s website or email address.

A brochure is often the first introduction to the support group and first impressions may be lasting. Brochures promoting support groups for suicide bereaved need not be costly, but should describe with dignity the reinforcement, understanding and safety to be found within a support group. The brochure content must be clear, specific and well organised. The brochure could include the group’s aims and purpose. Take into consideration the use of colours and imagery in keeping with sympathy, empathy and support. Examples of group brochures are provided in Appendix 11.

Group facilitators have found that people often read notices and keep them for a time before finding the courage and energy to attend their first meeting, so regular and consistent meeting times and venues are important factors in promotion.

Some countries have a well organised network of suicide bereavement support groups and maintain a state and national database of groups. Individuals and agencies can search for the closest group to their location using this database e.g. Lifeline’s Service Finder www.lifeline.org.au/find_help/service_finder.

Facilitators may use the media to the advantage of the group. There are specific guidelines for media engagement in the Australian Government Mindframe National Media Initiative. These guidelines have been developed to inform appropriate reporting of suicide and mental illness, in order to minimise harm and copycat behaviour, and to reduce the stigma and discrimination experienced by people with mental illness. The guidelines can be downloaded from www.mindframe-media.info/ and include information about:
• Issues to consider when talking to the media about suicide and mental illness
• Getting to know the media and how the media works
• Tools for working with the media
• Facts and statistics about suicide and mental illness.

A Quick Reference Guide is provided in Appendix 9.

2.4.6 Risk management

There are a number of risks that are involved with running SBSGs. The risks to be considered include but are not limited to:
• Accident and injury — public liability cover will be necessary from the time that you begin operating. A number of insurance companies offer this cover, or an insurance broker may be able to find the best rates. This is normally the responsibility of the auspicing organisation.
• Advice and harm — professional indemnity cover will be necessary. Professional associations often offer good rates to members.

• Unsuitability of support group for some members or potential members — referral protocols to other services will be required. Refer Section 3.1.4 Recruiting members and interviewing/checking for fit for more details.

• Emergency situations — a crisis protocol must be in place for potential emergencies including suicide or potential suicide, crises in the group, or crisis in the group leader(s) — refer Section 6.5 Risk & crisis management for more details and see Appendix 3 for the ‘Toolkit for helping someone at risk of suicide’. A SBSG facilitator may consider undertaking LivingWorks ASIST (Applied Suicide Intervention Skills Training) (see www.lifeline.org.au/learn_more/livingworks)

• Re-traumatising group members — group management practices are in place to reduce the likelihood of such occurrences. Refer Section 7.4 Group members at different stages of the grief process (Redirecting inappropriate disclosure) for more details on this.

• ‘Burn out’ of support group leaders — access to debriefing and supervision; co-facilitators are recommended, or time away from the support group leadership role may be needed. Refer Section 8 Staff and volunteers self-care and Section 9 The role of supervision in SBSG facilitation for more details.

• Conflict between members or leaders — effective conflict resolution processes included in Code of Ethics. Refer Section 3.1.3 Duty of care; Code of ethics; Confidentiality for more information.

• Media requests — media guidelines that clarify media release and spokesperson protocols. The Mindframe National Media Initiative provides guidelines (refer Section 2.4.5 Marketing, publicity, media and promotion).

2.4.7 Referral pathways and community networking

People bereaved by suicide may not themselves seek out an SBSG, or may be resistant to attending an SBSG, for many reasons. Networks within a community are a valuable way to bring information to an individual, to let them know of the support that exists and encourage and assist them to attend.

Where a SBSG facilitator becomes aware of a bereaved person in the community through a third party (e.g. friend rings with a person’s details), being cognisant of privacy and confidentiality reasons it would be appropriate to check whether permission has been given to make contact. Contact should only be made if permission has been given by the bereaved person.

It may be useful to establish a list of individuals and agencies most likely to come into contact with those bereaved by suicide. Ensure that they have current information about the group and brochures to hand out. A SBSG facilitator may consider giving regular presentations and newsletter articles. Given staff turnover, it is important to regularly provide reminders to relevant agencies.
3. The Suicide Bereavement Support Group

3.1 Group type and framework

One aspect that groups consider is how they can provide a sense of familiarity and stability. A simple, structured program provides security for those bereaved by suicide. Meetings regularly held in the same comfortable, neutral venue contributes to this security.

There are different approaches to structuring the group:

- A psycho-educational support group model is where the group has multiple aims: education, mutual support and coping development. The underlying premise is that people bereaved by suicide benefit from learning more about suicide and the grief and loss journey. Such a support group may be led by a mental health professional (such as a counsellor, psychologist or social worker), perhaps in collaboration with a person bereaved by suicide. Alternatively, a psycho-educational model is adopted by some suicide-bereaved facilitators. At each meeting there will be a part of the meeting devoted to talking about some aspect of grief in order to educate group members and express, validate and normalise experiences. Mutual support is encouraged in group discussions throughout the meeting.

- A self-help or mutual-help group model has the aim of providing emotional support. As the name implies, mutual-help groups are usually led by people who have been bereaved by suicide, who after a period of time from their own loss, contribute to the support of people who face a similar experience to one that they have been through. Suicide bereaved facilitators model to those newly bereaved that there is hope. Often a self-help group may run in three parts: informal welcome, formal sharing, and networking time. The formal sharing segment may include a short input or educational information and discussion, for example, handling anniversaries.

Further details are discussed below under Section 5.2 Meeting format.

Decisions will need to be made about the group, such as:

- whether an open format will be adopted, where meetings are regularly held on an ongoing basis and are open to any person who seeks to attend
- whether a closed format will be adopted, where meetings are scheduled for a specified period of time, for example, eight weekly meetings and with the same people attending each group meeting
- whether the support group will be face-to-face or will operate using other modes, such as by telephone or online.

3.1.1 Types of support groups

Deciding on the type of group that you will offer is important. SBSGs have differing structures and processes. There are four main categories of support groups. These are:

- open groups which have ongoing regular face-to-face meetings with open access and departure of members
- closed groups which operate for set time periods, often between 2 to 6 months, and with set membership for the time period of the group’s existence
- telephone groups which operate via telephone for set time periods and with a set membership
- on-line support groups accessed via the internet.
Some features of the differing group structures and processes that should be considered are as follows:

<table>
<thead>
<tr>
<th>Type of Group</th>
<th>Considerations and Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open group</td>
<td>Ongoing and accessible&lt;br&gt;Meets a wide community need&lt;br&gt;Members may attend at any time&lt;br&gt;Membership changes regularly&lt;br&gt;Group cohesion may not be as strong&lt;br&gt;Maintaining group leadership and group size may be challenging</td>
</tr>
<tr>
<td>Closed group</td>
<td>Provides concentrated support over a specified period of time&lt;br&gt;Deeper consideration of specific issues&lt;br&gt;Strong interpersonal relationships develop&lt;br&gt;Group cohesion strong&lt;br&gt;Finishes after a specific period&lt;br&gt;Limits referrals, as people have to wait until the next group</td>
</tr>
<tr>
<td>Telephone group</td>
<td>Accessible for those in rural and remote locations&lt;br&gt;Appealing to those seeking anonymity&lt;br&gt;Specific language groups can be accommodated&lt;br&gt;Decreased interpersonal cues&lt;br&gt;Decreased group cohesion</td>
</tr>
<tr>
<td>On-line group</td>
<td>Accessible for those in rural and remote locations&lt;br&gt;Appealing to those seeking anonymity&lt;br&gt;Decreased verbal and non-verbal cues&lt;br&gt;Issues relating to developing trust may arise&lt;br&gt;Requires technology (computer, internet access)</td>
</tr>
</tbody>
</table>

The choice of type of group will be dependent on many factors, for instance, skills of the facilitators, commitment/availability of facilitators, funding available, leadership available, community need, organisational/sponsor requirements. Some communities offer one or two fixed term closed groups per year (often weekly or fortnightly for 8–10 meetings) at the same time as offering ongoing monthly open groups. This gives closed group ‘graduates’ an opportunity to continue to make connections with other suicide bereaved and also gives new participants an opportunity to be involved with a SBSG before committing to a fixed term closed group. Many people just want the reassurance and comfort provided by attending one or two meetings and knowing that they could ‘drop-in’ on an “as needs” basis. Some require the build up of trust and comfort that is an integral part of closed group fixed term format. Furthermore, if a community offers a psycho-educational information evening once a year on the topic of “Suicide and its aftermath”, this can be enough of a connection for some bereaved people and fulfil their needs without having to attend a group. Such a public meeting can clarify the role and purpose of a SBSG, raise awareness in the general community and also reduce the stigma of suicide. There are many factors that need to be taken into consideration and perhaps a community needs to trial a number of options to determine which format suits their community best.

3.1.2 Access and membership

A group should clearly define the people for whom it is intended. For instance, the group may be open to those bereaved by suicide and their support persons, as long as they find the group of relevance to their grieving and support purposes.

Sometimes, conditions for membership may be considered, such as age, gender, cultural or linguistic background, type of relationship with the person who has died, or length of time
since the loss. The reason that conditions of membership may be applied to a particular group is to encourage attendance by members who share similar characteristics and who may not otherwise attend.

One consideration might be whether attendance at the group by those who are not processing grief is appropriate. For instance, researchers and students may request to attend. There are issues raised in such a situation. Opportunities to educate the wider community assist in reducing the stigma sometimes associated with suicide. On the other hand, a person who is not processing grief may upset the dynamics of the group. The group leader/facilitator should consider such situations on their merit, including the consideration of the support group members’ needs to feel safe and secure and for confidentiality, and the facilitator’s need to ensure that the support group process is not compromised. A specific meeting time could be set up for others to meet with support group members if considered appropriate. The education of the wider community may be better approached through a separate process.

Another consideration is whether the group is suitable for children or adolescents. For children under 16 the grieving process unfolds differently than in adults. Consequently, groups for children and adolescents should be designed to meet their particular needs. Refer Section 11.1 Children and adolescents for more details.

It may be necessary to consider other special needs of people who wish to attend the group. For instance, those with mobility disabilities may need special facilities such as ramps and disabled toilet facilities; those with language difficulties may require the use of an interpreter. The leader/facilitator may ask new people wishing to attend the group of any special needs that exist at the initial contact/interview stage (refer Section 3.1.4 Recruiting members and interviewing/checking for fit).

### 3.1.3 Duty of care; Code of ethics; Confidentiality

The SbSG has a duty of care to ensure the safety of its members and its facilitators. A duty of care is the obligation owed to anyone whom it is reasonably foreseeable would be injured by the lack of care of that person. For a duty of care to arise, there must exist a relationship of proximity (closeness) between the person or body owing the duty and the person or body to whom the duty is owed. The duty of care may be owed by, and to, an auspice body, the support group service providers and support group members (Department of Families, Community Services and Indigenous Affairs, 2007).

The central guiding principle for support group facilitators should always be ‘Above all, **do no harm**’. There are a number of aspects that the group leaders/facilitators need to consider, examples include:

- Where group facilitators are bereaved by suicide, they need to have integrated their loss sufficiently so that they can facilitate at a level that does not create greater harm for themselves.
- The activities that the group members undertake do not lead to greater harm.
- Some members may be in need of other services to assist them with their grief process.
- A group member may act inappropriately which creates harm for other members.

The SbSG facilitator may consider a Code of Ethics that they will adopt. A Code of Ethics that applies to group facilitators and leaders may be appropriate. Examples of such Codes are in Appendix 12.

Whilst the SbSG facilitators may adopt a Code of Ethics that guides their own group facilitation and co-ordination, it is good practice to collectively establish with the group a ‘Code of Ethics’ or group ground rules that will guide the members. By working collaboratively on this, there is a higher likelihood that members will abide by the group rules. However, it is also possible, for expediency sake, to develop a prepared document to which members can have input.
The following is adapted from the World Health Organisation guidelines (2008):

1. Group members will respect the rights of all to confidentiality. Thoughts, feelings and experiences shared by the group will stay within the group, which means that members have the privacy to share their thoughts and feelings.

2. Group members will recognise that thoughts and feelings are neither right nor wrong.

3. Group members will not be judgemental or critical of other members, and will show acceptance.

4. Group members have the right to/or not to share their grief and/or feelings. They should make some spoken contribution to the meeting, but if they wish just to “be there” at times the group will accept that.

5. Group members come to the group with empathy (fully comprehending the impact having experienced the situation), not sympathy (sharing another persons’ thoughts or emotions).

6. Group members appreciate that each person’s grief is unique to that person. Respect and accept what members have in common and what is particular to each individual.

7. Group members respect the right of all the members to have equal time to express themselves and to do so without interruption.

8. The group acknowledges that each person is the authority on their own experience.

(for more on this, refer to Section 5.4 Setting ground rules)

Privacy and confidentiality must be respected. This includes:

- Membership details
- The content and discussions of meetings must not go beyond the meeting
- Secure physical storage for group member records and group information.

An exception to privacy and confidentiality is in the event of danger or threat to life. Group leaders need procedures to deal with risks (refer Section 6.5 Risk & crisis management).

3.1.4 Recruiting members and interviewing/checking for fit

Suicide bereavement support groups are not suitable or desirable for everyone. It is advisable therefore, that prospective group members undergo an interview to check for fit. This process seeks to establish who may be suitable for a group and to establish the mix of any group gathering. The interview may take place after a referral from an external provider or self referral. The group facilitator or coordinator usually conducts an individual interview.

Although the support group type may have an open membership policy, the interviewing process is to check whether the needs of the bereaved person would be best met through group support. Facilitators would check to ascertain those who may not yet be ready for group work in which case alternatives may be offered including: individual counselling, relationship or small time-limited group, family therapy, journaling, or bibliotherapy (reading self help books or websites). Checking for fit also provides an opportunity to determine those with significant mental health issues, drug and alcohol issues, etc., which may impair an individual’s ability to participate.

An example of a structured interview tool is provided in Appendix 6.

Once accepted, information may be made available to members about:

- group structure/composition and lines of support
- strategies used to ensure safety of group members
- code of ethics
• venue information
• insurance coverage
• additional information about external support services, including 24 hour crisis services e.g. Lifeline 13 11 14
• resources and literature about self-care while attending the group.

For those who are not accepted into the group, information about the reason and referral options should be provided.

Specific relationships

One consideration for group facilitators are shared relationships that potential group members have with the person who died, i.e. two or more people grieving the same suicide. Larger open groups may find it easier to include more than one family member or person connected to the person who died. It may be valuable for parents or siblings or adult children or spouses to have an opportunity to discuss common reactions, emotions, coping techniques, etc.

In a closed group however, due consideration should be given to the potential for splits and alliances which can undermine the support of group members and impede group bonding. Having two group members who share a relationship to the person who died may be best avoided to encourage greater freedom for individual expression and less complex group dynamics. However, this may be difficult to put in place if the support group was the only form of support within the area and ran on an open group basis. Also, two people who were related or connected could offer mutual support or encouragement to attend. Such ‘paired recruitment’ can provide encouragement to ‘debrief’ after the group and provide information about the grief process for other family members. Refer Section 7.2 Family dynamics for further discussion on family members in groups.

It may be useful to have men meet as a small group at some meetings. Some differences in coping styles between men and women have been identified in the research. Men often enjoy walking groups, with its sense of purpose and walking shoulder to shoulder (as opposed to face to face group setting).

It may be valuable to separate parent couples in small groups. This allows the individual parent to discuss issues he/she may not feel comfortable to discuss in the presence of the other parent.

Children

Children do not usually benefit from support group meetings with older members. They may become distraught or disruptive and adult members are not as willing to share and be open with children present. Children or adolescent support groups, however, may be helpful. It is important to find referrals to children’s programs that are available for these purposes. Refer to Section 11.1 Children and adolescents for more details.

3.1.5 Support group records

The support group will keep details of members including the member’s name, address, phone number, and the name, relationship, date of death and age at death of the person who died by suicide. This information allows the group facilitator/coordinator to identify and connect a newly bereaved member to a member who has a relationship commonality. It also allows the coordinator to send newsletters and anniversary cards.

The coordinator may also choose to make contact with group members who miss meetings. An example of a card you may choose to send to members who miss two consecutive meetings is provided in Appendix 7.
4. Staffing

There will be a number of people, whether paid or volunteers, providing their time and assistance to operate a successful support group. A designated coordinator is recommended to ensure that the support group is planned and run to meet its aims and objectives. The coordinator can be the contact point to field enquiries from potential members or community agencies making enquiries. The coordinator may or may not be a support group facilitator and may or may not be paid.

In some communities, there may be a very small number of people involved in running the support group. Facilitators are encouraged to join appropriate networks of support group facilitators so that they may obtain support from other avenues. Refer to Section 13 Resources.

A support group should always have two or more facilitators to share the workload. This is because the empathic involvement is demanding of a facilitator’s personal resources and the debriefing of facilitators is imperative. At least two specifically trained and ‘skilled’ facilitators are highly recommended in all support groups. If a facilitator is suicide bereaved, it is recommended that an assessment process be undertaken to determine the person’s readiness to facilitate a SBSG and their willingness to access additional support as necessary (refer Section 8 Staff and volunteers self-care). It is suggested that a minimum of two years since the person died be considered before an individual facilitates a group, although individual people will take different periods of time. Also it is suggested that evidence of the potential facilitator’s integration of their own grief and self awareness be sought.

It is good practice to develop a ratio of facilitators to members. Generally this would be 1 to 10 and no less than 1 to 15. It is also recommended that there be at least 2 facilitators at each meeting regardless of number of members, as a safety check for the individual facilitators and to be able to adequately attend to group needs. For example, a larger group with a membership of 50 may need five co-facilitators, whereas a smaller group with a membership of 6 would still need two co-facilitators.

4.1 Selecting group facilitators

Facilitators need to meet key criteria, including:

- caring and empathic skills
- knowledge of the area of helping, of the grief process and suicide, of suicide prevention, and
- the ability to facilitate groups and work as a team.

An example of selection criteria for a group facilitator is provided in Appendix 8. It is important that facilitators demonstrate that they meet the minimum requirements, because the guiding principle “Above all, do no harm” must be adhered to. Well meaning or keen volunteers may not understand this and may need to be directed to the roles that are most suited and address safety concerns. The “Above all, do no harm” principle is not an excuse to abrogate duty and do nothing, but to be aware of the potential and actual impact of one’s actions and behaviours. These factors can be addressed by carefully selecting and training facilitators. It is suggested that the selection process include a ‘checking for fit’ similar to that established for SBSG members (refer to Section 3.1.4 Recruiting members and interviewing/checking for fit).

It is strongly recommended that Facilitators have received training in order to be able to best support those bereaved by suicide attending the group (see Section 13.2 in the Resources section for further information). SBSGs are demanding and challenging to facilitate. Concentration and
sensitivity to the extreme pain and confusion being expressed must be maintained and managed with a view to safety for all participants. It is not a job for the faint-hearted or novice facilitator. Experience, compassion, knowledge, and training are basic requirements for effective facilitation.

It is common for those bereaved by suicide to express their own suicidal thoughts and feelings. Given the elevated suicide risk for SbSG members, facilitators should have training and experience with suicidality. Facilitators should be comfortable to speak about suicide and regularly and openly monitor the risk of all group members. See Section 6.5 Risk & Crisis Management for further discussion.

4.2 Staffing roles and responsibilities

Different roles will be required for different types of groups and with different formats. Some roles may include:

4.2.1 Coordinator of SBSG

The coordinator’s role and responsibilities may include:

• Overseeing the overall process
• Co-ordinating with the auspicing body (if appropriate)
• Ensuring legislation, standards and guidelines are met
• Managing finances and related reporting (if appropriate, or this may be part of the auspicing body's responsibility)
• Developing, updating and disseminating the group's policies and procedures
• Responding as the initial contact person
• Welcoming new members at meetings
• Recruiting and supporting the team
• Supervising and debriefing facilitators (group or individually)
• Planning for the exit and succession of group facilitators, as they find they are ready to move on
• Promoting the SBSG and dealing with relevant media
• Seeking sponsorship and funding
• Keeping records.

The coordinator may also be a support group facilitator, although they may not be the lead facilitator at any particular support group meeting.

4.2.2 Group co-facilitators

The group co-facilitator’s role and responsibilities may include:

• structuring and preparing for the support group meeting
• welcoming each member as they arrive, and especially pairing new members with more experienced members if deemed appropriate
• attending pre- and post-group meetings
• facilitating the group processes
• managing time throughout the meeting
• ensuring that everyone has the opportunity to have a say, if they wish, and that no-one dominates
• identifying the members who are particularly distressed and vulnerable, assessing the support needed outside the meeting
• facilitating extra support if required
• providing assistance in the event of an emergency situation. For example, ensuring a member has opportunity and access to one-to-one support if required
• undertaking peer support and/or debriefing with co-facilitators.

In a co-facilitation arrangement, the relationship between the leaders has a very important modelling function. This may include promoting a sense of safety and security within the group. For this reason, it is important that the roles and tasks between the facilitators are clearly defined.

Each facilitator will bring different skills and experience to the group. It is important that the facilitators function in a complementary style, each taking responsibility in particular areas of the group process.

4.2.3 Other support group team members

There are many other responsibilities that team members may take. These may be undertaken by the coordinator and/or other facilitators may be coopted to assist. Other responsibilities include:
• booking venue
• organising tea and coffee
• putting out and organising name-tags
• supervising sign-on sheet/attendance log
• arranging seating and tissues
• greeting and welcoming new people
• following up individuals between meetings
• maintaining information and resources library
• maintaining records
• undertaking administrative tasks.

4.2.4 Support group mentor

An SBSG facilitator may seek the support of a grief mentor. The mentor may be a representative of the auspicing body or from any other agency, who has specific knowledge and expertise in supporting those bereaved through suicide. An example may be where a mentor is asked to attend a meeting. In such a case, the mentor would take a low profile and would provide professional credibility and present facts when myths surrounding suicide are an issue. A mentor may also provide debrief/supervision support to facilitators after meetings.
5. The SBSG Meeting

5.1 Meeting place

5.1.1 Venue

Selecting a venue that is located in the community, which is easily accessible, can help to break down stigma and to raise the awareness of suicide bereavement as a community issue. Factors such as central location, ease of transportation and parking are also important.

Community centres and other community facilities can often be used free-of-charge or at a low cost.

Other important considerations include:

- accessibility
- availability on a permanent basis — secured booking
- private and confidential room
- comfort
- safety
- a suitably sized room for the number of attendees expected
- space for breaking into small groups if required as part of the meeting activities
- kitchen space for refreshments
- comfortable amenities.

Meetings in a work-setting or neutral setting provides credibility, and with respect to open groups, these settings cater best for the ongoing nature of such groups, as opposed to meeting in people’s homes which can compromise effective group process. Meeting in a community setting may provide a dual benefit by showing that suicide is a community issue and should not be hidden away.

5.1.2 Occupational Health & Safety

Throughout Australia there is Occupational Health and Safety Legislation which governs how organisations provide a safe working environment for both staff and the general public. When developing a SBSG there are a range of Occupational Health and Safety issues, physical and psychological that need to be considered, including:

- ensuring that the venue is free of hazards that may cause injury
- ensuring that adequate facilitator levels are maintained so as not to over burden facilitators (refer Section 4 Staffing)
- ensuring that care strategies for facilitators are in place (refer Section 8 Staff and volunteers self-care).
5.2 Meeting format

The routine of support group meetings serves a purpose. It offers a consistent forum for mourning and sharing in a world where everything has changed, where nothing makes sense and where grief may be obsessive. A structured format reassures the member that there is safety, sanity and orderliness available.

Some groups like to have a focused ‘topic’ for each meeting, either pre-designated or suggested by group members (e.g. ‘Guilt’, ‘Dealing with holidays’, etc.). Some things to keep in mind when considering using a designated topic in support groups include:

<table>
<thead>
<tr>
<th>Considerations when using a ‘topic’</th>
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</thead>
<tbody>
<tr>
<td>Discussion of a topic can act to ‘warm up’ for group members</td>
</tr>
<tr>
<td>A topic can encourage group members to see other perspectives and views, for example, integration and hope</td>
</tr>
<tr>
<td>A generalised topic or issue can be used after a long, ‘awkward’ silence to get the group verbally engaged again</td>
</tr>
<tr>
<td>The topic chosen may not be relevant to some group members</td>
</tr>
<tr>
<td>The topic may dominate the time which could otherwise be used in group sharing time</td>
</tr>
<tr>
<td>Use of a topic may reflect a facilitator’s unease with silences</td>
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</tbody>
</table>

5.2.1 Psycho-educational support group

The educational component in a psycho-educational support group need not be an ‘expert’ giving their views. This component is about offering information that others have found useful in their grief journey. A short talk or activity on a specific issue may provide a general framework for further discussion.

The mutual support component in a psycho-educational support group allows members to talk about whatever they feel the need to discuss. The role of the facilitator is to create a supportive atmosphere for sharing. Those members who wish to talk should have a chance to share and, similarly, there should not be undue pressure placed on members who did not wish to talk at that time.

An example of a format for a two hour psycho-educational group is as follows: (NSW Dept of Forensic Medicine, SAS Group, used with permission)

- welcome, self-introduction of facilitators, outline of format for meeting
- the group ground rules as developed by the group are read
- news or other items of a general nature
- the group is opened with an opportunity for each member to introduce themself and their person who died
- reading of a poem and an invitation to spend a minute in reflection as a way of honouring the memory of the persons who died is made
- a short talk relating to a prepared, specific topic or issue is held (refer to Appendix 4 for ideas on topics for discussion)
- the group (if large) is broken into small groups of about 6 to 8 people
- small groups discuss and share – perhaps on the issue at hand and/or other pressing concerns, an opportunity to share grief, coping strategies, struggles and even humour and positive times
- the group reconvenes for informal sharing about key insights from small groups
• the facilitator asks members to reflect on ‘what the group has been like for them tonight’ to assist members to move from emotions to thoughts – this sometimes elicits contributions from members who have not previously shared. It also addresses safety concerns and encourages members to be present while they travel home.

• the group is closed formally on a positive note

• members are reminded that sometimes they may feel worse after a group and that this is normal. The group has given them an opportunity to go to places they may not normally go. This can bring up strong feelings and is a normal part of the grieving process. Members are encouraged not to let this dishearten them and to return for future meetings.

• members are invited to stay and talk over tea/coffee.

Support group times may vary, particularly with an open group, and often extended social interaction may occur. It is important that the group facilitator gives clear advice about timing available for social interaction.

5.2.2 Mutual-help support group

Many support groups that operate on a mutual-help or self-help model follow a three-part meeting format. The components are:

• welcome

• formal sharing as a group

• wind-down and informal sharing and support.

Mutual-help support groups may last for one to two hours, depending on the number of members, their needs, and other social activities which may be included or available e.g. coffee/meals.

The above segments are detailed below: (Stebbins, 2000; Archibald, 2003 & 2005)

Welcome

The Welcome segment is an informal ‘transition’ period that allows people to move into the support group and leave the ‘outside’ world behind. This segment may include:

• having tea and coffee available

• assisting new members to pair up with other members so that they feel they know at least one other person

• completing administrative aspects such as writing name tags and recording attendance and contact details on arrival.

Depending on size and nature of group, this segment may last around 15 to 20 minutes.

Formal sharing

This segment is a more formal part of the meeting. The group meeting commences. This segment may include:

• welcoming of members, new members may be welcomed by name

• reading a poem or short recital may help focus the group

• stating the purpose of the meeting, to give and receive comfort for the loss and grief resulting from the suicide of someone loved. This reaffirms the worth of the one who has died and the worth of the bereaved and allows members to recognise that externalising emotions and feelings is necessary and healthy

• outlining/reiterating the ground rules (see Section 5.4 Setting ground rules)
The SBSG Meeting

- facilitating introductions around the group, with each person introducing their name, the name of the person who died, and how long ago (at the discretion of the facilitator depending on the group, for example, in a small closed group this may not be necessary after the first meeting)
- providing a short input time to help members settle into the group. Input might consist of discussing grief, stigma, support of families and friends, ideas and strategies for building hope
- sharing of stories by members and discussing the issues and grief they are experiencing. It can be useful to do this by systematically going round the group or you may choose to invite members to randomly share as they choose as this reduces the pressure of expectation and reminds members that silence is OK. To start this, model the process as well as to model integration and resilience, one of the facilitators might begin by briefly introducing themself and share some aspect of their experience. During this main part of the meeting, the facilitator invites people to share, for example, ‘How have things been? How are you coping at the moment? What issues are you facing?’ Special days and events may require attention. The discussion and sharing may focus on approaching anniversaries, Christmas, Mother’s Day, Father’s Day, other significant experiences, etc.
- acknowledgement and validation of issues and topics that arise during the sharing by members. In this segment there is:
  - a reflective sharing of what has worked for group members and how others could use this skill
  - a normalising response which acts to reassure members that their experiences are normal.
  - (for large groups) discussion in small groups where those with similar experiences may gravitate together
- before moving to the close, there may be announcements such as the date of the next meeting, special events such as seminars or memorials, requests for volunteers to help with sending out newsletters, etc.
- closing the formal part of the meeting may include summarising the main points that have been expressed, reinforcing the support of each other, and acknowledging the courage of everyone, particularly the new members. The facilitator lets people know that they may feel tired and even down over the next day or two, and that their continuing participation may likely bring longer-term benefits. Finally, the facilitator might close with a short poem or reading.

As this segment closes, it is important to check the wellbeing and safety of the members, including the ability to drive if appropriate. The facilitator may identify members who would benefit from a follow-up phone call after the group and discuss this with co-facilitators.

This segment might take 1 to 1½ hours.

**Wind down, Informal sharing and refreshments**

Following the formal part of the meeting, offering refreshments provides an opportunity for members to connect and engage in a more intimate space.

Informal sharing and refreshments allows members to:
- gain and give further support
- complete unfinished discussions
- seek out members to whom they related to engage at a deeper level of sharing (if they so chose), and
- (for the facilitators) provide further support for those members who are especially vulnerable.

This segment also provides a transition back to the ‘outside world’. This segment may take about 15 to 30 minutes. The facilitator will need to be aware of booking times for the venue and if there is continuing availability of the venue.
5.3 Planning and preparing for a meeting

Preparation in relation to the venue has been discussed previously in Section 5.1.1 Venue.

As well as planning for the way the meeting will be facilitated (see Section 6 Facilitating the group), the leader or coordinator of the support group will need to consider a number of factors in planning for a meeting:

- ensuring there are adequate facilitators available for the meeting (refer Section 4 Staffing)
- preparing the topic or information session (if applicable)
- clarifying meeting procedures and meeting resources with all facilitators
- discussing any personal issues that may have arisen that may interfere with facilitator support roles.

Preparation for the meeting may also include:

- arranging the furniture appropriately before the meeting — different groups prefer different arrangements. Chairs in a circle promotes no barriers between those bereaved, and provides an opportunity to connect and encourages physical reinforcement in the form of hugs and touches of encouragement, however, it may relate to vulnerability. Some groups like to sit around a table.
- considering other ways you make the space inviting, such as flowers, ornaments, refreshments, etc. You may need to consider factors such as gender of members (e.g. be aware of making the space too feminine where there are male members) or cultural aspects (e.g. indigenous artworks for groups with indigenous members).
- preparing resources (books, tapes, etc) for members to borrow — have a register to record borrowing and returning (refer Section 5.5 Information and resources for group members)
- preparing sign on sheets so a record of members attending is obtained — this also allows facilitators to contact new group members a few days after the meeting (refer Section 5.7 Between meeting support) and may be necessary for various reasons such as public liability insurance, emergency evacuation procedures, etc. Asking for third party contact details may be helpful in some situations (refer Section 2.4.6 Risk management).
- have handouts with meeting details, facilitators and contact numbers for support for new members such as emergency contacts, etc.

Other materials that are useful may include:

- name tags (sticky labels & a marker)
- notepaper, pens
- tissues and receptacle for used tissues
- soft toys, ‘trauma teddies’
- coffee, tea, sugar, milk, cookies/cake, cups, urn, etc.

Note: Consider having a ‘materials box’ with a checklist of the materials required attached to the outside.

Maintaining a register of members is also a good idea so that you have necessary details in a crisis situation or where concern for a member may necessitate contact. A precaution is that membership details are confidential. Members may access their own details occasionally to update; however, the membership register should not be an open document. Groups should be aware of privacy principles (Refer Section 3.1.3 Duty of care; Code of ethics; Confidentiality).

5.3.1 Meeting schedule

It is important to determine a meeting schedule that can be nominated and adhered to without change, e.g., the first Tuesday of each month at 7.30pm at a certain venue. Try to avoid dates that will conflict with public holidays. Also consider the schedule of other support groups that might
be within driving distance. Some group members may seek to attend other meetings for support between your group’s meetings. It is important to keep to the nominated schedule as people may retain information (e.g. a flyer) and access the group at a later point in time.

5.4 Setting ground rules

It is important to establish the culture and tone of the group. Setting rules for group discussion, or ground rules, may be a tool that helps to do this. Ground rules may be developed as a collaborative exercise with the group members or alternatively, the facilitator may introduce them. For example, in an open group where membership is relatively fluid, facilitator-developed ground rules may be appropriate. In a closed group, where the membership is more stable, the development of ground rules may be part of the early establishment of the group.

Ground rules help to create a sense of safety and boundaries for group members. Knowing that the facilitator will encourage other members to adhere to these agreed upon rules may help members feel safe to share. For example, at the beginning of the meeting the facilitator may reiterate that one of the group’s aims is to give everyone who wants to, an opportunity to share. Given this, as facilitator, he/she may request permission to interrupt and move the conversation along if necessary. Setting clear boundaries in this way may assist in the smooth running of a group and contributes to developing a safe environment for group members.

An example of a set of ground rules is provided in Appendix 5.

5.5 Information and resources for group members

A SBSG may provide free information and access to a wide range of resources. Having something tangible to take home and process between meetings may be useful.

Information and resources may include:

- books
- articles and fact sheets
- poems and personal stories
- website details
- lists of local services and organisations which provide assistance, such as local health services, community and voluntary agencies and professional organisations.
- details of special events such as memorial services, grief/bereavement workshops, information evenings or similar activities.

A system for borrowing may be required. For instance, a log or card index files.

5.6 Special days and anniversaries

Days such as birthdays, wedding anniversaries, anniversary of death, Christmas, Mothers Day or Fathers Day may hold special significance to those bereaved by suicide. The facilitator may acknowledge these special days through checking their member logs and may suggest other group members to lend support through difficult times.

Anniversary cards may be a service provided to acknowledge the importance of the anniversary of the person’s death. The card helps to validate the sense of loss that the bereaved person feels. If anniversary cards are sent, the support group will need to consider how long they will continue this practice.
5.7 Between meeting support

A follow-up phone call may be appreciated by a new group member after their first meeting. Also, it may be deemed important for a group facilitator to make contact in the week following the meeting with any members that facilitators feel concerned about between meetings. Sharing for the first time may be frightening and the ‘low’ that often happens after attending a meeting may sometimes last for several days – new members may need extra support and encouragement in normalising this experience and recognising the potential longer term benefits of group meetings. Contacting group members may also be helpful if conflict, or tension, has occurred within the group. In a mutual-help support group, the group member may be ‘matched’ to a facilitator who has experienced similar issues. In any group meeting, sharing and/or expressing emotions may lead some to feel unsure about returning next time. Over disclosure in one meeting can sometimes cause embarrassment on later reflection and discourage further participation.

If appropriate, it may be suggested that group members exchange phone numbers/email addresses for between meeting support if they choose.

Another idea is to provide members with the phone number(s) of a volunteer member(s) who is experienced and willing to provide between meeting support. The facilitator may develop such a contact list.

Facilitators should be clear from the beginning of a group about how they will provide or not provide between meeting support and under what circumstances. They will also consider how to provide appropriate referrals for between meeting support for individual members with greater needs as well as how to encourage further help-seeking by members where needed.

5.8 Referral services

A regularly updated resource directory for referral to other services is important to maintain. Referral to other agencies such as mental health teams, psychologists, counsellors, support groups in other geographical areas, multicultural mental health teams, etc, may be needed. It is important to know how to refer a person on to other/additional supports and to know how to normalise counselling and referral to counselling. Referral to the person’s general practitioner may also be appropriate, especially if physical symptoms occur.

The coordinator or facilitator may need to develop such a directory or gain access to online directories, such as the Lifeline Service Finder www.lifeline.org.au/find_help/service_finder.
6. Facilitating the group

A SBSG facilitator uses their skills and knowledge to facilitate the group in the support process and to encourage members to develop between meeting contacts. The facilitator assists group members to develop their own ways of working collaboratively and to advance ideas to support everyday functioning. Facilitators listen, encourage and support discussion, and help the group stay on task. The job of a facilitator may look easy but experienced facilitators know that this is not the case. While an effective facilitator uses their facilitation and communication skills to lead the group, they do not monopolise the discussion. They are comfortable with silence; they know how to gently encourage a member, as well as how to manage a dominating member.

6.1 Facilitation skills

It is desirable that a facilitator have the following skills and attributes:

- good listening skills
- good interpersonal and group communication skills
- “Best Practice” facilitation skills
- an understanding and appreciation of others’ feelings and the unique experience of grief
- ability to be non-judgemental and to be open to people’s different experiences, values, beliefs and opinions
- ability to manage ambivalence to changing dysfunctional emotions, behaviours and thoughts
- able to deal with difficult situations and moderate conflict
- self awareness of own responses to situations
- self knowledge of their own attitudes, values and beliefs about suicide and its impact
- ability to deal with diversity
- time management skills
- clear and evenly-paced voice
- ability to respond to challenging incidents and to activate preventative measures where needed.

A facilitator doesn’t:

- believe that the group is ‘their’ group – group members need to feel that they have some ownership of the group
- dominate discussion
- dictate what the group will discuss
- lead members to have unrealistic expectations of the group
- attempt to run a therapy group (unless fully trained and the group purpose is clearly identified as a therapy group)
- breach confidentiality.

Co-facilitation requires effort by the facilitators to:

- be clear about each other’s role and who will do what
- agree about the objective and purpose of the support group
- get together to plan each meeting
• get together after meetings to discuss issues what arose during the meeting and allow time to debrief
• discuss differences, problems and tensions with each other (where needed).

### 6.2 Facilitation techniques and tips

This section has techniques and tips for facilitating a support group. Section 7 discusses some further challenges and difficult situations that may arise in a support group.

Some general facilitation techniques include:

- you are responsible for facilitating the session but this is not the same as chairing the session – your voice should not be dominant.
- ensure everyone has an opportunity to contribute if they wish.
- keep the focus on the goals of the group while also maintaining some flexibility to meet immediate group needs.
- listen carefully and acknowledge all contributions to the discussion – such as a simple thank you or “that’s a very important point”.
- to foster discussion use prompts such as “would anyone else like to add to that?” or “has anyone else had a similar experience?”
- greater depth and clarification of discussion can be encouraged by clarifying for participants what has been said – “what I think you are saying is…”
- discussion can be encouraged by checking that people understand what is asked of them or the nature of the issue under discussion – “does that make sense?” or “has anyone got any questions?”
- realise you do not have to have the answers – you are not the teacher… invite the group members to use their experience and knowledge – “What do you think about that?” or “What have been others experience of that?”
- it can be helpful to summarise the key points of the discussion for the group – “So what we’ve covered so far is…”
- seek members’ agreement to undertake tasks, in preference to directing members.
- step in and facilitate direction if the group is off task, experiencing difficulty getting started on an activity, or experiencing interpersonal conflict.
- identify the “less experienced” members of the group and ensure they are supported to participate in the discussion.
- remember your role is to facilitate not to teach or lecture.
- silence is OK – avoid jumping in.

Maintain your passion… and a sense of humour!

Some further tips follow:

**Suggest, don’t direct: suggestions may be made if appropriate**

Facilitators ask permission to give a suggestion, for example: ‘Would this work for you…?’, not ‘You should do this’. Facilitators elicit suggestions from the group. A question to the group such as ‘What other approaches might be helpful?’ will encourage other members to help one another. Try to avoid negating a member’s opinion. For example, ‘You may wish to investigate a different approach’ suggests the member is capable of choices and decisions, compared with ‘You need to find a better approach’ which suggests the member isn’t doing the right thing. An effective facilitator tries to restore control to the person and empower them to manage their grief. The role of the facilitator is not to make a suggestion, but to summarise the suggestions put forward by the group.
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Comparing grief: block members who compare grief
A facilitator may hear statements such as 'That’s nothing compared to what happened to me'. There is nothing that will be gained from such a comparison. Facilitators need to guide the bereaved to the recognition that, for everyone, their loss and grief is probably the most devastating occurrence in their life. Depending on the situation, the facilitator may say, for example, “We've all been through something similar. No-one's situation is worse, though it sometimes may feel that way. Our experience is never going to be exactly the same as each other. But there are also many feelings that we share in common.” This models moving the conversation away from content into process which may assist with processing of grief.

Dominating members: work to ensure those who wish to contribute have the space
Some suicide bereaved people, when they feel the relief of speaking about what happened, may begin to dominate the discussion. Generally those dominating will need to be interrupted, except perhaps someone who is newly bereaved who is being given an opportunity to ventilate feelings at length. When necessary to interrupt a person you may say 'We wish there was time for you to share more with us, but I know you understand that others need to share as well.' Or ‘We have 20 minutes to share … we have 10 minutes left and I’m concerned that other people get to share.’ When parameters are established as part of ground rules (refer Section 5.4 Setting ground rules), boundaries may be more easily managed. Another strategy is to encourage those members who might model useful sharing.

Redirecting inappropriate disclosure or the commencement of over disclosure
In depth descriptions of death scenes may impose secondary trauma upon other group members. When a bereaved person begins to give vivid descriptions of the body, the scene or how death was instrumented, the facilitator may say 'I hear that it's important for you to talk about what you saw (heard, felt) but let's arrange a private time to discuss what took place.' Or another example “I’m concerned that such details may be upsetting for some group members. Let’s share in a way that considers other people”. Following the meeting, the facilitator may suggest that the member find a more appropriate place/person than the support group (e.g. a counsellor, mental health professional, or pastor) to talk about such details.

Discussion about suicide prevention
Extended discussion about suicide prevention may magnify guilt, especially among newly bereaved people. Although it is important to learn about the issue of suicide, effective learning is done at the pace of the bereaved person. Information about suicide and suicide bereavement may be helpful, and access to current resources may be important for members. However, it is important for the facilitator to know about suicide prevention themselves, so that they may recognise a bereaved person who may be at risk of suicide (refer Section 6.5 Risk & crisis management).

Recognising difficult times: acknowledge all members
Many bereaved people find that the anticipation of difficult days such as anniversaries and birthdays is worse than the actual day itself. The facilitator may encourage the experienced members to share how they have coped and this may assist in removing some of the dreaded anticipation. The facilitator may also have an education session on 'Coping with Approaching Holidays' and/or ‘Ways of Honouring Those We Miss during Holidays’ during November and December meetings.
Managing silence: allow for silences

Don’t panic when no-one immediately responds to the invitation to share. Silence may come from members trying to gain composure to speak. Silence may be the more experienced members giving the newer members a chance to speak. There are positive aspects of allowing silence, for example, silence may encourage a member to elaborate, or it may encourage another member to come into the discussion. When silence becomes prolonged and uncomfortable, the facilitator might offer a topic for discussion. However, facilitators need to recognise that point and not ‘jump in’ too soon.

Swearing

There are times during sharing when expletives seem the only way of expressing the intensity of feeling for some members. However, swearing may be offensive to others, may damage the dignity and for these reasons, should be discouraged in meetings. Such challenges may be addressed in formulating the group rules.

Misinformation: provide clarification where misinformation emerges

If a member makes a statement that the facilitator knows is misinformation or biased, they may want to wait to see if other members make a correction. If not, the facilitator may say ‘There was a time when that was believed to be true, however research (or mental health professionals or other authority) have learned differently…’.

Finishing positively

Finishing on a positive note, or with a good feeling, is desirable. Ask participants to share a positive occurrence in their life or what they have got out of the meeting; or summarise some of the key points made earlier about resilience and hope; or use a poem or inspirational reading.

6.3 Approach towards facilitation

A facilitator needs to be clear about the communication model they will adopt in the group. Many facilitators use a client-centred communication model, or non-directive model (Egan 1986). This model is underpinned by the belief that people can self-determine their journey to healing, or with bereaved people to integration, in a climate of unconditional respect and empathic understanding. The bereaved telling and retelling their story may contribute to the gradual development of clarity and re-engagement of control.

It is beyond the scope of these guidelines to expand on communication skills. Needless to say that working with those bereaved by suicide can be challenging and an active process as they clarify and confront painful emotions, explore confused thinking and find unhelpful patterns of coping.

A key aspect that facilitators need to monitor is self-disclosure. Disclosing their own learnings too early may be problematic. Although many group members report that the support group is a place where they can find true understanding, a facilitator must allow members to go through their own journey. Finding the balance is important. Sharing of similar experiences will help to offer hope and assist people in finding resilience.
6.4 Group dynamics and group theory

A facilitator may observe the group as a whole, the interactions between individual members, and interactions between the members and the facilitator to gain an understanding of what is happening in the group at any one time (adapted from NSW Mental Health Association, 2001).

For example, silence may be an indicator of different things. It may indicate people are thinking hard about a particular issue. It may indicate a lack of trust or a level of anxiety. It may indicate that the group doesn’t understand or that there are a lot of quiet people in the group. Observing the group dynamics will help the facilitator to identify the cause and therefore develop an appropriate solution.

A facilitator may monitor group dynamics:

• constantly throughout a discussion
• at regular intervals, e.g. every 15 minutes
• at the end of each segment
• when something unexpected happens.

When observing the group dynamics a facilitator may acquire information about:

• levels of trust
• patterns of communication
• levels of interaction
• body language
• roles and relationships
• patterns of dominance
• patterns of influence
• level of group effectiveness.

Generally, a group proceeds through a series of stages before it becomes effective and achieves its goals. One theory widely acknowledged is Tuckman’s (1977) Stages of Group Development which identified four key stages:

**Forming** – groups begin as members get to know one another, come together and get clear about why they are there.

**Storming** – group members might have different ideas about things such as how the group should operate, its objectives and what should be covered. These differences might cause conflict with one another.

**Norming** – as issues get resolved and the conflict subsides, members generally establish agreements on roles, guidelines, objectives and operating norms.

**Performing** – the group is able to complete the work they aim to achieve.

A suggested further stage is that of **Adjourning** where group members reach mutually agreed conclusions, thereby allowing the celebration of progress and sharing experiences including planning for “what next”.

These stages may take different amounts of time to proceed through, and generally occur for most groups to some extent. An open group with a changing membership may proceed differently to a closed group where members are more consistent. Having an understanding of these stages will help the facilitator to understand what is happening in the group. For instance, some groups may need assistance in moving through certain stages. By developing ground rules with the group, the facilitator is helping the group to establish operating norms.
6.5  **Risk & crisis management**

Support groups need a crisis plan which identifies a line of support and management processes for emergency situations. This relates to general emergency situations such as fire, illness, accident and also to situations specific to the risk factors due to the nature of the group, in particular suicidality.

In a crisis situation, the group facilitators are responsible for working with a group member who requires immediate crisis intervention. Crisis intervention should be provided in a location separate to the main meeting.

In a situation where a group member or co-facilitator is struggling with thoughts and feelings about suicide or some other life threatening behaviour, implement the following strategies:

- acknowledge the member's feelings. Express concern
- take the member aside — ask co-facilitator or experienced member to continue running the group
- have a list of emergency contact numbers
- undertake a risk review, e.g. ask the member whether they have a specific plan
- get help. Try to identify a trusted person (ask the member whom they trust such as a family member, friend or health professional) and offer to contact that person (you may use a third party contact from the sign on sheet — see Section 5.3 Planning and preparing for a meeting)
- don’t leave the member alone until you’re sure that he/she is in the hands of another responsible person
- if the member doesn’t want anyone, explain your concern and that you will have to contact the mental health crisis team or another professional

A crisis situation, particularly talk of suicide or self harm, will impact on other members in the group. Once the immediate crisis is over, set aside some time to talk about the group members’ feelings and thoughts in relation to the incident and let them know what action was taken to handle the person’s distress or crisis.

Crisis situations may also be stressful and upsetting for the facilitator. It is highly recommended that the facilitator debrief with someone about the incident (see Section 8.2 Pre-briefing, defusing and debriefing of facilitators).

Support group facilitators may find it useful to complete the LivingWorks Education Applied Suicide Intervention Skills Training (ASIST) course which gives practical awareness and skills for identification of a person at risk of suicide and for intervention. See [www.lifeline.org.au/learn_more/livingworks](http://www.lifeline.org.au/learn_more/livingworks) for further information.

6.6  **Strategies for members leaving the group**

Strategies for members leaving the group may vary depending on the nature of the group, such as whether the group is a closed group or an open group. Individuals have varying needs and a group may serve some of these needs.

In an open group many members will self-select out of the group within a period of time, this may vary from a few months to a few years following the person's death. Members may attend just one or two meetings while others may attend regularly for years. It may be useful to have a strategy developed so that it is clear to the member leaving and the remaining members what the circumstances are. For example, it may be very concerning for regular members to have a fellow regular member not attending in which case having a mechanism of clarifying the situation may allay anxiety for remaining members. Most people will know when they feel the need to stop attending the group, however, a facilitator could check with longer-term members to see whether
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the group is of continuing relevance to them — some people keep attending a group as a regular commitment without self-reviewing whether they need the continuing support. Further, services such as anniversary cards and newsletters may also no longer be relevant. Group members could be asked for their preferences.

Some people may find comfort in being able to return to the support group at a time when their needs change as issues ‘reignite’ their grief and bereavement. Facilitators will need to have entry, exit and re-entry strategies in place to meet members’ needs as they change over time.

Over time some group members may become interested in assisting the group in a more formal role. Strategies to help train volunteers to move into helping roles may be needed. Some support groups have interested helpers move into ‘trainee’ roles as they learn the skills of group facilitation or group co-ordination.

Over time some groups may gravitate towards being more of a social group than a support group. Facilitators need to be aware of this possibility, and develop a clear exit strategy for the facilitator when the group moves in this direction. A social group has different requirements than a support group. For example, a facilitator is not required, nor an auspicing agency.

6.7 Succession planning

Having an exit strategy is also true for facilitators. Facilitators may find after a period of time that they need to leave the support group. A variety of needs emerge in different stages of life, and these needs may mean that they are unable to continue. This is certainly acceptable. One of the advantages of having a co-facilitator arises in this situation.

It is important to have mechanisms in place to address potential facilitator non-attendance and personal circumstances which may lead to them no longer being able to facilitate the group as well as planning for the progression of facilitators. Such circumstances may be the source of much anxiety for some group members, as being left behind (abandoned) may be an all too familiar feeling. Putting mechanisms in place ahead of time may ensure the smooth running of the group and least disruption. Further, a facilitator may feel trapped by their sense of loyalty to the group, particularly if there is no-one who is able to succeed them.

Planning for succession may include:
• having a co-facilitator
• training experienced members of the group as a co-facilitator
• developing networks with professionals who might be interested in facilitating the support group.
Section 6 Facilitating the group has already introduced typical situations that a facilitator may encounter. Facilitators may find that they come across a range of difficult and/or challenging situations in support groups. Generally the tools facilitators may use include:

- conflict resolution strategies
- referral to other services
- exclusion strategies where needed.

Some ideas on handling specific situations follow.

### 7.1 Group members affected by drugs or alcohol

Consideration may include the level to which behaviour is affected in the support group. The ground rules may also include reference to intoxication by drugs/alcohol by members at meetings (refer Section 5.4 Setting ground rules). One facilitator may need to manage the situation with the individual who is affected by drugs or alcohol, while the other facilitator continues with the support group. The facilitator may need to:

- remain non-judgmental and provide a referral for help (such as counselling, rehabilitation) if needed
- discuss referral options with the drug/alcohol affected member and provide a resource list
- consider safety issues (such as how the individual will get home safely).

### 7.2 Family dynamics

There may be different reactions from different family members if they are attending the same group meeting. Some examples include anger, guilt, blame or judgements. Family relationships may be very complex. Closed groups may consider whether it is appropriate to have more than one family member in a group where there appears to be complex relationship issues. This is important and may need to be considered as part of the interviewing and checking for fit process (refer Section 3.1.4 Recruiting members and interviewing/checking for fit). Particular family members may find that different types of support are needed, and referral to other options such as youth groups, or information sessions, or grief counselling may be appropriate.

Where family dynamics become problematic in a group, such as one member verbally attacking another member, the facilitator may need to interrupt counter-productive behaviour. This may be required for safety reasons, to protect the family members as well as the other group members. The facilitator may need to refer back to the ground rules (refer Section 5.4 Setting ground rules) relating to non-judgemental behaviour. The facilitator may also need to normalise the potential anxiety around the negative feelings that the family member has been having, such as the anger, or frustration, for guilt. For example, the facilitator may say something like “Many of us have had these feelings…” or “Angry feelings are normal. It’s ok to talk about them but we need to respect each other.”
7.3 Angry or judgemental outbursts

Some members may have an angry or judgemental outburst in a support group meeting. If the anger is frightening, loud or threatening, then the safety of the group members will be a paramount concern of the facilitator. For instance, newer or more fragile group members may find such behaviour frightening. In such a situation the facilitator may wish to:

- address the problem by politely interrupting. For example if the member has just cut off another member, the facilitator may say “Sue can we hear some more from John, and then we can come to you?”
- go back to the individual after other members have had their input, as the individual hopefully will reframe their comments in a less judgemental way.
- suggest talking about the issue after the meeting or to seek counselling.

7.4 Group members at different stages of the grief process

Individual members may be at various different stages of their grief process. This may lead to situations such as inappropriate disclosure (refer Section 6.2 Facilitation techniques and tips — Redirecting inappropriate disclosure or the commencement of over disclosure) or the rawness of someone’s grief becoming a trigger for someone else. The facilitator may wish to consider some strategies to assist such as:

- separating those closer to their loss into a small group with a facilitator during some part of the meeting
- considering referral options if necessary (see Section 2.4.7 Referral pathways and community networking)
- for closed groups, considering checking for fit options (see Section 3.1.4 Recruiting members and interviewing/checking for fit)
- encouraging those not newly bereaved to support those earlier in their grief as those further along may have supportive aspects of their experience that may be comforting
- confirming that it is acceptable for people to consider leaving a group when they feel that they no longer need the support it provides (see Section 6.6 Strategies for members leaving the group).
8. Staff and volunteers self-care

Facilitating a support group can be very rewarding, however, it may also be stressful both physically and emotionally at times. It is essential that facilitators have access to regular supervision and debriefing processes. This will enhance the potential for facilitators to provide effective bereavement support in an environment of sometimes intense emotions and ensure that they can continue to do so for a period of time. The capacity of facilitators to model a level of stability during meetings may be strengthened or even determined by the level of their own support. Self-care strategies for group members must also be modelled by facilitators.

Some ideas on looking after facilitators’ own health and well being are:

- **proper nutrition, sleep and exercise**
- **follow debriefing guidelines**
- **reflect on the positive things that happen in the group, not just the negative**
- **ask group members for feedback — they will often be less critical than yourself**
- **share your feelings and thoughts with other facilitators**
- **take time out from the group if you need it**
- **recognise your own limits and boundaries.**

It is also important to ensure that there are sufficient facilitators for the support group.

As well as support from other facilitators within your support group, you may look for support from other avenues such as:

- **facilitators from other support groups — join a network of group facilitators**
- **suicide Prevention Australia**
- **American Foundation for Suicide Prevention's network of facilitator support [www.afsp.org](http://www.afsp.org)**
- **community health organisations.**

8.1 Vicarious traumatisation

Facilitators and group members often become secondary witnesses to the trauma experienced by group members.

Facilitators listen, support and validate the feelings and the experiences of group members. They offer the opportunity to let go of some of the burden. As witnesses, facilitators can’t help but take in some of the emotional pain.

Recognising that it is “normal” to be affected by this type of work is the most important coping skill that you can give yourself. Each person will be affected by the trauma in some way.

Facilitators must find a healthy balance to cope with the effects of vicarious trauma in their personal and professional lives. They must also take care to avoid the repeated invasion of the trauma into their lives. They must know the warning signs when the work is consuming their thoughts, workday, or personal life.

In summary, as professionals and volunteers in the helping field, facilitators must recognise their vulnerability to exposure to trauma. They must recognise the warning signs and be prepared to care for their own needs to cope with vicarious trauma.

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, it is recommended that you choose one item from each area that you will actively work to improve.

8.2 Pre-briefing, defusing and debriefing of facilitators

The pre-briefing, defusing and debriefing processes are essential for the maintenance of facilitators, and contribute to effective group support. All staff/facilitators should receive these opportunities and they need to be agreed between the coordinator/lead facilitator and staff/co-facilitators before a group commences. (Espie, L, 2008 pers. comm.)

Pre-briefing and Debriefing

All facilitators involved with a particular group (in attendance at a particular meeting or not) will meet both before a group meeting and after the group was held to discuss all aspects relevant to the group items/issues. This is a supportive way that assists those involved to acknowledge, in a team environment, the valued work conducted and help manage any potential or actual concerns.

The pre-briefing session may take 20 minutes to 1 hour and generally occurs immediately before the group meeting.

The operational debriefing session after the group has been held, may take between 30 minutes to 2 hours. It is suggested, if possible, to conduct the debriefing session on the same day the group is run or as soon as possible afterwards. The following may be included in the de-briefing session (Stebbins, J & S, 2000):

- ask each person how they feel
- ask each person for their reactions and impressions of the meeting
- discuss members who attended, and discuss members with particular concerns
- provide constructive feedback to each other
- allocate new member follow-ups
- confirm dates and details for the next meeting
- discuss any other tasks to be carried out.

Defusing

Defusing is the process of allowing the facilitators to talk about their thoughts, feelings, reactions and responses following a highly stressful event which may have occurred before, during or after running a group. Defusing can be either a one-on-one or group process and should be conducted by the coordinator or a senior supervisory manager. If a defusing is deemed necessary, this would take priority over the debriefing which would be rescheduled.

8.3 Care of members/attendees

Facilitators need to be aware of their duty of care to all group members. See Section 3.1.3 Duty of care; Code of ethics; Confidentiality for more detail.
9. The role of supervision in SBSG facilitation

9.1 Introduction

Supervision is a process of care and support delivered by a trained supervisor for facilitators running SBSGs. Supervision involves aspects of support, accountability, education, case presentation and debriefing. An auspicing agency may provide supervision services for group facilitators. These services may be internally or externally sourced.

Providing care and support for suicide bereaved people may be highly rewarding, however it may also elicit emotional reactions, tiredness and stress for those in the support role. Facilitators of SBSGs are strongly encouraged to avail themselves of regular supervision for the duration of their facilitation of group meetings. Supervision may also be accessed before a group starts and/or when a group has ended.

Supervision is a part of an overall commitment to self-care and professional support, whether a paid or volunteer facilitator. It generally offers support for the ‘whole’ person including opportunity to reflect on and discuss the group and the process of facilitating. It may also serve a function of debriefing and defusing as well as the provision of education and resources. In addition, organisational/administrative issues may be explored.

9.1.1 Elements of supervision

There are typically three elements of supervision practice: educational, supportive and administrative.

Educational supervision refers to skills-based development, whereby the individual’s knowledge and approach to practice is discussed and enhanced over time (British Association of Counselling & Psychotherapy, 2005; Basa, 2008). Educational supervision should also allow for the growth of awareness of internal reactions and responses, the dynamics involved with interactions, and the effects of various interventions used by the individual (Smith, 1996 & 2005).

The supportive element of supervision helps to deal with role-related stress, and optimises motivation and morale through the ability to share ideas, acknowledge and challenge negative thinking, and allowing the growth of self-awareness (The Australian Association of Social Workers, 2000). Supportive supervision could also encompass communicating confidence in the individual by the supervisor; validating their decisions where appropriate (Todd & O’Connor, 2005), and acknowledging their contribution to the organisation and developmental goals reached.

The administrative element of supervision incorporates the promotion and maintenance of good standards of practice whereby conduct is guided by policy and practice.

9.2 Purpose of and approach to supervision

The purpose of supervision is to provide a forum for facilitators to:

- discuss the clinical work of the SBSG with an experienced bereavement counsellor/group facilitator
- debrief issues that arise in the SBSG with the guidance of the supervisor
- identify any personal or other issues that arise, which can be either dealt with in supervision or safely referred
allow bonding and enhancement of group dynamics for each group of facilitators

• discuss and gain information about theories and models of group practice and bereavement work as needed

• discuss strategies for dealing with group issues and stressors for facilitators.

It is important for facilitators to attend to their own process in supervision so that they do not collude to block the expression of feeling or to engage in unhelpful avoidance during group meetings. Facilitators need to ensure that they maintain a fine balance between managing confrontation and containment of pain during group meetings. Fostering a supportive relationship and ensuring safety are central to facilitators working in SBSGs. In supervision the facilitator may find it helpful to explore and discuss:

• thoughts and feelings about the role

• relationships with other facilitators and staff as well as group members

• constructive and clear feedback and support

• grief and bereavement themes

• refinement of skills

• identification of paralleling experiences

• reflections on self-care strategies.

Some aspects of supervision that are important include:

• exchanging views with the supervisor on the supervision process and contract

• discussing and clarifying boundaries between supervision and personal therapy

• providing supervision that is congruent with the facilitator’s stage of development

• providing supervision that is reasonably congruent with the facilitator’s own theoretical orientation

• clarifying any organisational issues, e.g. ethical, assessment, boundaries or other responsibilities.

In SBSGs many and varied situations can arise that require reflecting on and sharing with someone outside the immediate situation. Supervision may be one on one, paired or small group. Consideration of the following guideline may be helpful:

• 1 to 1.5 hours of supervision for every group meeting (one on one), or

• 2 hours for small group supervision for each group meeting.

The supervisor may be within the auspicing body or may be from an external agency/organisation. Generally, supervisors qualified to provide this service would be counsellors, psychologists, social workers, bereavement/grief workers or pastoral carers. A fee for service may be required. This can be seen as an investment in facilitator well-being, personal and professional development, sustainability and in meeting occupational health and safety requirements. Choosing a supervisor who is well qualified, experienced and respected is important. You may have a session or two to see if the ‘fit’ is good for connection and developing an appropriate relationship.

Organisations may like to consider the benefit of providing external supervision which can enable a more objective setting for facilitators to process issues. Consideration may also be given to individual and/or group supervision to encourage facilitators to process their own personal issues relating to their facilitation as well as give an opportunity to nurture and process teamwork issues.

An example of an outline of a supervision session is provided in Appendix 15.
9.3 Role and responsibility of the supervisor

The supervisor is responsible for:

- monitoring wellbeing of facilitator/s and support group facilitation processes
- modelling facilitation processes
- ensuring confidentiality of discussions and issues raised in supervision.

9.4 Guidelines and confidentiality

The supervisor and facilitator/s agree that any discussion during supervision sessions is confidential and will not be discussed outside the supervision session.

All issues arising in supervision are confidential (unless legal obligations require mandatory disclosure).

Facilitators are encouraged to discuss operational/organisational issues that may be disclosed with their operational manager where agreed.

Facilitators first discuss with the supervisor any issues directly relating to supervision where necessary.

When using group supervision, each facilitator is encouraged to speak in turn and listen when others are speaking and the supervisor will encourage equitable time for each person, depending on the issues under discussion.

The facilitator(s) take responsibility for identifying issues for discussion in supervision sessions.

The supervisor will usually keep brief notes on each supervision session to facilitate discussions in subsequent supervision sessions and to ensure accurate (de-identified) reporting where reporting is required.
10. Ongoing operations

10.1 Sustainability

The support group sustainability requires a cohesive and dedicated team. It also depends on the cohesiveness and support gained by the group members. Involving members in responsibility for group operation such as meeting set up, small group leadership, refreshment duty and between meeting support may create greater ownership of the group.

Facilitator burn out is probably the greatest risk to the continuation of a support group. The support group should have a minimum of two facilitators so that responsibility and commitment are shared. In addition the support group should be aware of the need for succession and be aware of potential future facilitators.

The following useful ideas are from “Support Group Leader Tips and Hints for a Long-Lasting Group” (Archibald, 2005)

- the support group leader is not responsible for healing that does or does not take place within a meeting. Most suicide bereavement support groups are mutual support and the healing force is the sharing and reinforcement exchanged among group members.
- the leader/facilitator is the group’s verbal traffic director. The leader directs the flow of the meeting, encourages new attendees to feel safe and comfortable with sharing by following the example of veteran participants who speak openly of what happened and their coping mechanisms.
- name tags allow group members to direct personal responses to one another and the leader to address new attendees by name.
- the leader needs to be suicide-informed, enabling him or her to interject facts confronting guilt, blaming and misconceptions about people bereaved through suicide, as well as conduct suicide risk assessment when required.
- silence may strike panic in the heart of a leader — the awkward time during meetings when no-one speaks. Silence serves a purpose — while one member may be struggling for the courage to finally speak, another may be searching for the words to share his or her feelings. Silence is not to be feared, it is a time of contemplation, reflection and absorption. Silence, too, is a healing place.
- an effective leader identifies his or her loss but speaks sparingly of his or her own circumstances except when it is relative to what is discussed during a meeting.
- co-leadership allows one leader to occasionally be a group member where it is appropriate for him or her to give voice to his or her grief. It also enables leaders to protect themselves against burnout by taking a meeting off for a social event, go on holidays or just time to regenerate.
- support group leadership is a balancing act between caring greatly for the well-being of others and taking great care of the well-being of oneself. One cannot provide nourishment to others from an empty glass.

10.2 Service review, evaluation and development

The process of evaluation supports a continuous improvement focus to the operation of the support group. Continual review of the services provided by support groups is vital to address ongoing value and sustainability.
A formal evaluation process on a regular basis may assist in measuring the effectiveness of the support group against its stated aims and objectives. It can also be useful to determine if there are things that need to be improved/changed. An evaluation may be undertaken using methods such as:

• review of the support group against standards for good practice, undertaken by the staff or by an external reviewer
• feedback survey asking members for their views and opinions — this survey may be targeted at the support group itself or at specific services such as a newsletter
• focus group to gather qualitative information, ideas and suggestions for service improvement.

Evaluation may be conducted at the end of a closed (or time limited) group and annually for an open (or ongoing) group.

An example of feedback questionnaires used to gather feedback from members of a group is provided in Appendix 10.

10.3 Special occasions and memorials

Memorials and ceremonies can provide places for reflection and remembering that may provide comfort for some suicide bereaved people. These memorials and ceremonies can be personal and private or public and communal.

Some examples of personal memorials and ceremonies include:

• memorial corner in a home or garden
• rituals that acknowledge the person who died on special occasions like Christmas and birthdays.

Some examples of community memorials and ceremonies include:

**Memorial quilts**

Quilts are made with pictures of the persons who died.

**Memorial gardens**

A special area is set aside in a community facility, e.g. a public park, community centre, and tended to by a group. Such memorials may serve to de-stigmatize suicide and increase public awareness as well as offer a place to remember lives lost by suicide.

**Ceremonies**

At many workshops and conferences, memorial ceremonies are held to remember the persons who died.

**World Suicide Prevention Day**

Memorial ceremonies are often held in popular public locations, e.g. Sydney Opera House, Melbourne Town Hall. Seminars and information sessions are hosted to raise the profile of suicide bereavement support activities.

**Website Memorials**

A number of websites exist to post photos and memorials about persons who died by suicide e.g. [www.affirm.org.au/pages/page51.asp](http://www.affirm.org.au/pages/page51.asp)
10.4 Telephone groups

The differences in running a telephone support group as compared with a face-to-face support group include:

- limited non-verbal communication
- a reduced time limit
- challenges to keep everyone involved
- strong emotion that may be able to be expressed more easily on the phone than in a face-to-face situation
- the sudden beginning and ending of sessions (Shanley, 2001).

The optimal size of telephone support groups is less than face-to-face groups due a lack of visual clues, and perhaps only three or four members is appropriate. Prior posting of written material (such as the agenda, names of participants, and topics for discussion) to support group participants acts as a guide and contributes to time management. Some groups have found that members of a telephone support group wanted sessions to last a longer time than was scheduled and suggest that about two hours is optimal. Other groups have found that after one hour, ability of both members and facilitators to continue concentration levels is limited. Facilitators need to be flexible and innovative in their approach so that they can give members changes in pace (similar to having a break in a face-to-face group).

10.5 On-line groups

Another use of technology is the provision of online support groups. A popular online provider has a ‘Friends and Families of Suicides’ online support group. According to the message history count, between approximately 1200 and 2300 messages were logged each month in 2006.

Online groups may use a range of technologies including:

- video-conferencing (group members see each other and communication is synchronously)
- mailing lists (messages are emailed to all members of a group)
- chat rooms (group members synchronously communicate)
- bulletin boards (group members contributions are posted but communication is asynchronous).

Many issues that apply to face-to-face support groups also apply to online groups, including whether the group should be open or closed; group membership recruitment and screening; the role of the facilitator; adapting techniques to suit group phases; group ground rules; and adopting ethical standards. Members of an online group may face similar issues as telephone groups such as a loss in non-verbal cues as well as a loss of verbal cues (for non video-conferencing methods). Members need to be computer literate. There may be potential difficulties in developing trust due to these factors. Some people find the anonymousness of online groups a positive feature. Group leaders need to anticipate dynamics and issues specific to the online environment and manage them as effectively as possible.

Online groups must be aware of the difficulties of this form of communication. Issues of internet security and password access mean that privacy cannot be ensured. Information and advice cannot be effectively tailored to individual situations and is therefore open to being misunderstood and misconstrued. Online groups would be wise to contain disclaimers that privacy cannot be guaranteed and that the information contained on the site does not constitute treatment and does not replace professional advice.

William Feigelman (2008) in the USA is currently undertaking research investigating this form of delivery of support groups and has been providing some useful insights into the appeal, value and benefits provided by such groups.
There is an Australian peer support internet community and email support group, Parents of Suicide AUNZ (AUNZ-POS) for bereaved parents whose sons and daughter have suicided at www.parentsofsuicide-aunz.com/. There is also a Family & Friends of Suicide (AUNZ-FFOS) branch.
11. Specific populations

11.1 Children and adolescents

The needs of children in a family where a death by suicide occurs may be overlooked. A child may be very frightened and confused when a death in the family occurs. Parents’ and caregivers’ natural impulse is to protect children from the pain and discomfort. Central to helping children to cope and adjust is the need to include children in the grieving process, to be open and honest to the extent that they are able to comprehend, and to explore their knowledge and feelings on death and dying.

Children's reactions may be exacerbated by an incomplete understanding of the finality of death and may include:

- feelings of betrayal, abandonment, and rejection
- feelings of guilt if the child interprets their past misbehaviour as causing the suicide
- a fear of losing the other parent
- an impression of worthlessness; the parent did not value the child enough to live or preferred death to being with the child
- insecurity and clinging behaviour
- denying the death altogether or rewriting the nature of the death to protect themselves from the pain of having to talk about a suicide
- beginning to think of suicide themselves. (Centre for Suicide Prevention 2008)

A review of research findings suggests that suicide bereaved children exhibit clinically significant emotional distress, symptoms of anxiety, depression, trauma and difficulties with school and social adjustment. Further, children continue to revisit the suicide death throughout their life as they reprocess this event so it is important to provide early intervention and support to assist healthy grief outcomes as the child develops (Sands 2007).

Adolescents’ grief reactions may differ markedly from those of adults and may often be misinterpreted. Behavioural responses may be at either end of the scale from adopting a parent-like role not typical of their age group to adopting the opposite stance and ‘acting out’ to gain attention and assurance (WHO 2008).

Opportunities that are developmentally appropriate should be provided for children and adolescents to process their grief. A specific children's or adolescents' group could provide a setting for children/or adolescents to share their grief issues in an age appropriate way. Facilitation of such groups would require specific expertise and skills.

Group interventions have been utilised successfully for a number of issues impacting children and adolescents and a review of literature suggests that age appropriate groups are a more natural way of intervening with bereaved children than counselling (WHO 2008).

Young people's support groups have many similarities to adult groups. However, they also have many differences. It is for this reason that due preparation is advised. An invaluable resource for running children's groups can be found in Dianne McKissock's 2004 “Kids’ Grief – A Handbook for Group Leaders”.

Other resources are identified in the list of resources in Section 13.4 Children.
11.2 Aboriginal and Torres Strait Islander peoples

Having an appreciation for Aboriginal suicidology can assist in addressing the particular needs of Aboriginal and Torres Strait Islander (ATSI) people bereaved by suicide (Tatz, 2001; Elliott-Farrelly, 2004). Given the diversity within the ATSI communities, the particular needs of this group in regard to suicide bereavement may vary from region to region. In respect to all the traditional owners, it may be appropriate to listen and learn about the cultural practices and protocols specific to the relevant region. It is also important to understand that within any culture, individuals and families may vary in regard to their adherence to the practised norms.

Suicide is a relatively recent public health problem for ATSI communities and its impact has followed an accumulation of devastating social health problems that are affecting mortality and longevity. As for all cultures, suicide is a sensitive issue and any bereavement support services or workers who wish to include or accommodate ATSI people should learn whether it adds value to the support already being provided within the local indigenous community and whether proposed services are appropriate for this community.

The concept of bereavement as it is related to Indigenous Australians may be considered in the context of the Indigenous culture, knowledge systems and experience. Some guiding principles may include (Murray, 2001; Hanssens, 2007):

- **Respect** for Indigenous people, their culture, their experiences, their spirituality, rituals and customs, and their spirit of hope and healing through sharing their stories, their knowledge and their grief.
- **Understanding** that bereavement is experienced by Indigenous people not just on a cognitive level but also at a social, emotional and spiritual level.
- **Enablement** can occur on many levels from individual to whole communities, as well as broader national and international levels. It challenges us to find ways of caring for Indigenous Australians within our systems to prevent further loss through premature death and lead towards healing.
- **Reciprocity and obligation** requires that Indigenous people have cultural obligatory requirements after the death of family and community members that override all other commitments and constraints and can extend through kinship connections across family groups within the community or to neighbouring communities.
- **Cultural safety** requires that while the community is experiencing the aftermath of a suicide as a traumatic event, the whole community is ‘at risk’ and that safeguards and response plans need to be set in place to assess suicide risk within the community.
- **Cultural security** needs to be maintained within the family and whole community after a death and may incorporate the Indigenous council making decisions about restrictions, for example, restricting access in and out of the community during ‘sorry business’; restricting sales of alcohol immediately after the death and during and after the funeral.

Contextual factors may predispose or amplify the experience and response to traumatic experiences such as death by suicide. Due to the importance of extended kinship systems, a loss is likely to be felt broadly throughout the kinship group, rather than confined to the immediate nuclear family. That is, a person may have several mothers or be considered a mother to several nieces/nephews/grandchildren and if this is not recognised, the intensity of the loss may be underestimated. In addition, given the frequency of traumatic events in Indigenous communities, a broader approach may be required. A further complication is that cultural practice may prevent public acknowledgement or talking about people who have died.

ATSI people may want to go to the home of the person who has died. The family may go through some traditions to make sure that the person's spirit is shown respect and can find peace. This is the responsibility of certain family members. This is often known as ‘sorry time’. After sorry time, cultural practice prevents public acknowledgement or talking about people who have died.
Specific populations

Some practical advice that may be relevant, appropriate and useful depending on regional cultural norms may include (adapted from ACPMH, 2007):

• observe cultural norms including no direct eye contact
• do not refer to a dead person by name
• do not refer to certain close relatives by name (a Torres Strait Islander male may not refer to his brother-in-law by name)
• do not criticize an elder or other member of the extended family
• be aware of confiding certain personal information to a member of the opposite sex as men's and women's business are usually kept separate
• spiritual experiences are not necessarily hallucinations or delusions
• allow for reflection, periods of silence and any questions
• minimise the use of direct questions.

SBSGs that include Aboriginal and Torres Strait Islander people may consider involvement of ATSI people in the staffing team, including involvement of ATSI people in planning and in facilitation of the group. In particular, SBSGs may consider involving ATSI in discussions and planning regarding local support services and allow them the opportunity to direct how those services might best meet the needs of their people. Further, SBSGs may consider developing resources with the local ATSI community in order to avoid the production of written material that is not useful or appropriate to their needs.

A useful brochure Spiritual and Cultural Well-Being After a Suicide — for Indigenous Communities (Queensland Health) is available (see Section 13.7.3)

An excellent reference is Colin Tatz's book, Aboriginal Suicide is Different: A Portrait of Life and Self-Destruction (for full reference refer Appendix 16).

Other resources are identified in the list of resources in Section 13.7.3 Aboriginal and Torres Strait Islander.

11.3 Culturally and linguistically diverse (CALD) peoples including refugees and asylum seekers

There are many factors that influence an individual's reactions to bereavement. One factor may be culture and family background (adapted from material provided by Multicultural Mental Health Australia). Bereavement differs among cultures in its presentations, effect on the family and the community as a whole. It is important as a preliminary understanding when working with culturally and linguistically diverse communities to not fall into the habit of stereotyping cultures and generalising.

The culture's rituals may not meet the needs of all individuals within the culture, and so it is important to ask group members or potential members about how their culture deals with suicide, how their cultural environment has helped or hindered their grief, and how much they identify with their culture (McKissock, D & M, 2003). Don't assume that all people from a particular culture experience grief similarly. It is also important to ask the individual how they express their loss outside their cultural environment.

Suicide is seen as a grave sin in some cultures and the family may be stigmatised from their community and may feel that they have a mark of shame on them or they will inherit the condition. This may be seen in some fundamentalist Muslim and Christian cultures where religion is a strong factor in the culture.
Suicide is seen as unacceptable in many different cultures and is difficult to talk about. Those bereaved by suicide may find it hard to mourn due to the stigma of suicide in their community. The bereaved may not seek support or help due to the overwhelming stigma and may find it difficult to access support groups. It is important to involve community leaders and multicultural welfare workers in the design, setting up and running of support groups and also to promote the groups in their community.

In some cultures people are not viewed as individuals and their identity is expressed in relation to their family. When there is a suicide in the family the entire family may feel their name has been tainted in the community and that the suicide affects their standing in the community as an individual.

Some cultures find it easy to speak on suicide and for others it is a taboo. Further, some Asian cultures discourage the open display of emotions so it may be difficult to draw out these individuals in a group setting.

It is important to identify if there is any sense of stigma experienced by the individual and how they feel about discussing their feelings in a wider group. A first step may be to meet with the person bereaved by suicide before attending the group and work towards making them feel welcome and comfortable, and refer them to a community leader or multicultural worker for additional support. Refer Section 13.7.4 Multicultural for contact details of Transcultural Mental Health Centres in each state as these Centres can assist with support and information. It is also a good idea to keep a list of community leaders and multicultural welfare workers as part of your resources.

Facilitators will also need to be patient and accept the cultural differences of each individual. Try to avoid jumping to conclusions and forming stereotypes, as much will depend on how far the individual identifies with their culture. Facilitators can acknowledge their limitations and differences and try to convey a desire to learn about customs to be able to more effectively offer support.

Refugees and asylum seekers have often been exposed to the following experiences, and may need referral to more specialised services:

- trauma (experienced or witnessed violent and tragic situations where their lives have been threatened or people have been killed)
- loss (of family friends and relatives, possessions, livelihood, country, status, etc.)
- deprivation (of food, water, shelter, education and medical attention).

They may be already traumatised from their life experiences in addition to their experiences of grief and loss from suicide. Additional complex factors such as language, cultural, socio-political and community issues are also involved and facilitators may feel overwhelmed with these complexities. However, genuine interest and respect are the most effective tools for building trust and a supportive relationship (adapted from ACPMH, 2007). A respected leader in the community may be able to assist in identifying issues, developing strategies and supporting potential group members.

Further, groups that include CALD members may consider involvement of CALD leaders in the facilitation team as the level at which a person identifies with their culture may impact their needs.

Other resources are identified in the list of resources in Section 13 Resources.
12. Other options to meet needs in the community

Not all people bereaved by suicide will seek support from a group. Some people may attend one meeting and not return. Some may attend once or twice and then choose to return at a later stage. Some may find that the pain expressed during the group magnifies their own grief and leaves them feeling vulnerable. Each individual will have different needs.

Other options for support may include:
- information evenings
- seminars
- individual counselling
- individual readings
- newsletters (see Section 12.1 Newsletters)
- a telephone support group
- an online group.

Refer to Section 10.4 Telephone groups and Section 10.5 On-line groups about these latter types of groups.

Some people may wish to have a permanent memorial space for their persons who died such as a garden in a community park or a memorial plaque in an area operated by a funeral home. Other people attend memorial ceremonies on World Suicide Prevention Day – 10 September. Some people find memorial websites a good way to remember their person who died.

There is a caution that may need consideration for physical memorial sites in public places due to the possibility of the ‘contagion’ factor.

Some people bereaved by suicide may need support during the coronial processes. Each state and territory has differing coronial processes. Details of each state's processes will be found on the relevant websites (see details at Section 13.6 State/Territory Coroner’s Office or Court). An information flyer on the process in one state is provided at Appendix 14.

Members of particular cultural groups may have special needs that groups may be able to meet. Section 11.3 Culturally and linguistically diverse (CALD) peoples including refugees and asylum seekers explores this further.

12.1 Newsletters

Regular newsletters may offer support and validation to group members and non-group members alike. Newsletters may be sent to:
- currently active members
- people who no longer attend and wish to remain on the mailing list
- people in rural and remote areas, and
- people who cannot access the group.

Editing and publishing a newsletter is a time-consuming task and may be expensive. Ways to reduce cost may be through email distribution wherever possible or perhaps by seeking sponsorship such as a printing or funeral company.
Group members may be invited to contribute to editing, preparing and distributing newsletters. Material may come from other newsletters, from poems or books or other publications, with permission from the author to reprint in the newsletter.

It is important to ensure that privacy of group members is maintained. For example, the names and addresses of newsletter recipients should not be accessible to group members other than the group facilitator.

Newsletters may be an excellent way to connect the community of bereaved people living in rural and remote regions. Just receiving a quarterly newsletter, for example, may give an individual a sense of shared experience, of connectedness and belonging, of not being alone and may provide hope. Knowing that a group exists may provide a level of comfort and security.

An example of a SBSG newsletter (NSW Dept of Forensic Medicine) is provided in Appendix 13 and others are listed in the Section 13.7.5.

Many suicide bereavement support organizations provide newsletters to support the bereaved however they are often only available via a contact list mail out (or email list) rather than openly available on the internet.
Listed below are some resources which may be useful to those facilitating Suicide Bereavement Support Groups.

### 13.1 Listing of Suicide Bereavement Support Groups in Australia

Details about groups operating in your area (by State/Territory) can be located on the Lifeline Australia website:

### 13.2 Group facilitation and suicide bereavement support training

- **Eric Trezise undated**, “One step at a time” Training Manual for an Eight-Week Recovery Workshop & Individual Client Counselling for the Bereaved by Suicide, PO Box 6114, Kincumber NSW 2251
- **LaRita Archibald 2003**, *Heartbeat Survivors after Suicide, Groups of Mutual Support, Leaders Guide* heartbeatsurvivorsaftersuicide.org/docs/guidelines.doc
- Salvation Army, Living Hope Bereavement Support online Training suicideprevention.salvos.org.au/
- Healing after suicide: the legacy of suicide: support groups for the bereaved/Lyn Bender for Lifeline Melbourne and The Victorian State Coroner’s Office, 1999
- Australasian Facilitators Network www.facilitators.net.au/
- International Association of Facilitators www.iaf-world.org/i4a/pages/index.cfm?pageid=1
- Australian Facilitator Networks www.iaf-world.org/i4a/pages/index.cfm?pageid=3311
- Groupwork Institute of Australia www.groupwork.com.au
13.3 Client-centred counselling


13.4 Children


Guidelines for supporting children and young people bereaved by suicide – help sheets – Jesuit Social Services, Support After Suicide www.supportaftersuicide.org.au


National Centre for Childhood Grief www.childhoodgrief.org.au

Winston’s Wish website www.winstonswish.org.uk/ For grieving children and their families

The Dougy Center www.dougy.org/ For grieving children and their families, USA

RD4U is a website designed for young people by young people www.rd4u.org.uk

Skylight www.skylight.org.nz/ NZ site offering support to children, young people and their families through change, loss, trauma and grief.


Reach Out! is an Australian website for helping young people through tough times. au.reachout.com/find/issues/loss-and-grief


Telling Children About Suicide, Centre for Suicide Prevention, Calgary, Canada: www.suicideinfo.ca/csp/assets/alert22.pdf

Child Survivors of Suicide, Centre for Suicide Prevention, Calgary, Canada: www.suicideinfo.ca/csp/assets/alert69.pdf


School based resource developed by MindMatters (Mental health & wellbeing in schools) relating to Loss & Grief www.mindmatters.edu.au/resources_and_downloads/mindmatters/loss_and_grief.html
13.5 General grief and bereavement


Australia Bereavement Care Centre www.bereavementcare.com.au

Grieflink www.grieflink.asn.au/frameset.html an information resource on death-related grief for the community and professionals (based in South Australia)

Australian Centre for Grief and Bereavement www.grief.org.au, A comprehensive list of online Grief & Loss sites can be found within this website at: www.grief.org.au/internetl.html

National Association for Loss & Grief – NALAG

Victoria – www.nalagvic.org.au

NSW – www.nalag.org.au


www.omh.state.ny.us/omhweb/grief/

13.6 State/Territory Coroner’s Office or Court


Western Australia – www.coronerscourt.wa.gov.au/
## 13.7 Research sources and contacts

Current research and statistics about suicide, mental health and mental illness in Australia can be obtained from the organisations listed below (from Mindframe website at www.mindframe-media.info).

### 13.7.1 General

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Website</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auseinet (Australian Network for Promotion, Prevention and Early Intervention for Mental Health)</td>
<td><a href="http://www.auseinet.com">www.auseinet.com</a></td>
<td>(08) 8201 7670</td>
</tr>
<tr>
<td>beyondblue</td>
<td><a href="http://www.beyondblue.org.au">www.beyondblue.org.au</a></td>
<td>(03) 9810 6100 OR Info line 1300 22 4636</td>
</tr>
<tr>
<td>Black Dog Institute</td>
<td><a href="http://www.blackdoginstitute.org.au">www.blackdoginstitute.org.au</a></td>
<td>(02) 9382 4523</td>
</tr>
<tr>
<td>Clinical Research Unit for Anxiety Disorders</td>
<td><a href="http://www.crufad.com">www.crufad.com</a></td>
<td>(02) 8382 1720</td>
</tr>
<tr>
<td>Mental Health Research Institute of Victoria</td>
<td><a href="http://www.mhri.edu.au">www.mhri.edu.au</a></td>
<td>(03) 9388 1633</td>
</tr>
<tr>
<td>Queensland Centre for Schizophrenia Research</td>
<td><a href="http://www.qcsr.uq.edu.au">www.qcsr.uq.edu.au</a></td>
<td>(07) 3271 8660</td>
</tr>
<tr>
<td>SANE Australia</td>
<td><a href="http://www.sane.org">www.sane.org</a></td>
<td>(03) 9682 5933 OR Helpline 1800 187 263</td>
</tr>
<tr>
<td>Suicide Call Back Service</td>
<td><a href="http://www.suicidecallbackservice.org.au">www.suicidecallbackservice.org.au</a></td>
<td>1300 659 467 Referral Line</td>
</tr>
<tr>
<td>Suicide Prevention Australia</td>
<td><a href="http://www.suicidepreventionaust.org">www.suicidepreventionaust.org</a></td>
<td>(02) 9568 3111</td>
</tr>
</tbody>
</table>
13.7.2 Tool Kits & Factsheets

From Lifeline Australia website: www.lifeline.org.au/find_help/info_service/toolkits
- Survivors of Suicide — A compassionate resource developed by those bereaved to support other people who have lost a person to suicide. www.readthesigns.com.au/__data/assets/pdf_file/0019/30772/SOS_Final_Oct_06_reprint.pdf
Copies available from Lifeline at infoservice@lifeline.org.au or (02) 6215 9400

From Sane Australia website: www.sane.org
- Is someone close to you bereaved by suicide? www.sane.org/information/factsheets/is_someone_close_to_you_bereaved_by_suicide?.html
- Has someone close to you with a mental illness gone missing? www.sane.org/information/factsheets/has_someone_close_to_you_with_a_mental_illness_gone_missing?.html

From Commonwealth government’s Living is for Everyone website: www.livingisforeveryone.com.au

13.7.3 Aboriginal and Torres Strait Islander

<table>
<thead>
<tr>
<th>Auseinet (Australian Network for Promotion, Prevention and Early Intervention for Mental Health) Aboriginal and Torres Strait Islander Section</th>
<th><a href="http://www.auseinet.com">www.auseinet.com</a></th>
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<tbody>
<tr>
<td>Australian Indigenous Health Infonet</td>
<td><a href="http://www.healthinfonet.ecu.edu.au">www.healthinfonet.ecu.edu.au</a></td>
</tr>
<tr>
<td>LIFE: National Suicide Prevention Strategy Aboriginal and Torres Strait Islander Section</td>
<td><a href="http://www.livingisforeveryone.com.au">www.livingisforeveryone.com.au</a></td>
</tr>
<tr>
<td>Office for Aboriginal and Torres Strait Islander Health (OATSIH)</td>
<td><a href="http://www.health.gov.au">www.health.gov.au</a></td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:oatsih.enquiries@health.gov.au">oatsih.enquiries@health.gov.au</a></td>
</tr>
<tr>
<td></td>
<td>Phone: (02) 6289 5027</td>
</tr>
<tr>
<td>Vibe Australia Aboriginal media and events</td>
<td><a href="http://www.vibe.com.au">www.vibe.com.au</a></td>
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</table>


Emotional well-being toolkits for indigenous communities developed by Lifeline Australia:
- Help when you are feeling down www.lifeline.org.au/__data/assets/pdf_file/0011/8489/Lifeline_HelpWhenDown_Toolkit_Feb09.pdf

Healing your Spirit, Surviving After the Suicide of a Loved One. 2006 Calgary, Canada [www.calgaryhealthregion.ca/programs/mhip/healingyourspirit.htm](www.calgaryhealthregion.ca/programs/mhip/healingyourspirit.htm)


### 13.7.4 Multicultural

<table>
<thead>
<tr>
<th>Multicultural Mental Health Centre</th>
<th>Phone</th>
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<tbody>
<tr>
<td>ACT Transcultural Mental Health Network</td>
<td>(02) 6205 1178</td>
</tr>
<tr>
<td>Migrant Health Service, Adelaide</td>
<td>(08) 8237 3900</td>
</tr>
<tr>
<td>Multicultural Mental Health Australia (MMHA)</td>
<td><a href="www.mmha.org.au">www.mmha.org.au</a></td>
</tr>
<tr>
<td>Tasmanian Transcultural Mental Health Network</td>
<td>(03) 6332 2200</td>
</tr>
<tr>
<td>Victorian Transcultural Psychiatry Unit</td>
<td><a href="www.vtpu.org.au">www.vtpu.org.au</a></td>
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</table>
13.7.5 Newsletters

**ARBOR News**  
Ministerial Council for Suicide Prevention, WA  

**Surviving Suicide**  
American Association of Suicidology  
[www.suicidology.org](http://www.suicidology.org)

**Lifesavers**  
The American Foundation for Suicide Prevention  
[www.afsp.org](http://www.afsp.org)

**The Journey**  
The Link Counseling Center  
Atlanta, GA, USA  
[www.thelink.org](http://www.thelink.org)

**Comforting Friends**  
Friends for Survival, Inc.  
Sacramento, CA, USA  
[www.friendsforsurvival.org](http://www.friendsforsurvival.org)

**Survivors After Suicide**  
Didi Hirsch CMHC  
Suicide Prevention Center of Los Angeles, USA  

**Survivors of Suicide Loss**  
San Diego, CA, USA  
[www.sossd.org/newsletter.htm](http://www.sossd.org/newsletter.htm)

**Solace Newsletter**  
Survivors of Suicide Support Group  
Alachua County Crisis Center, Florida, USA  

13.8 Online resources

13.8.1 Coping with grief at Christmas time

Coping with Grief at Christmas (NALAG New South Wales) including coping strategies  

Managing grief at Christmas (Reach Out! Australia — for young people)  

Special Occasions (Jesuit Social Services, Support After Suicide)  

Handling the Holidays — US AFSP resource  

Surviving the Holidays (Compassionate Friends)  
13.8.2 Australian resources


ARBOR [www.mcsp.org.au](http://www.mcsp.org.au) Suicide bereavement resources and information on WA based website


Includes three publications:
- After a suicide death: information for families and friends
- At the time: when someone you know has died by suicide
- Coping with grief after a suicide death


Salvation Army Hope for Life [suicideprevention.salvos.org.au](http://suicideprevention.salvos.org.au) 1300 HOPE LINE or 1300 467 354 and Living Hope online Bereavement Support Training

Jesuit Social Services, Support After Suicide [www.supportaftersuicide.org.au](http://www.supportaftersuicide.org.au) Extensive resources relating to suicide bereavement on Victorian based website

Parents of Suicide AUNZ (AUNZ-POS) a peer support internet community and email support group for bereaved parents whose sons and daughter have suicided. [www.parentsofsuicide-aunz.com](http://www.parentsofsuicide-aunz.com)

There is also a Family & Friends of Suicide (AUNZ-FFOS) branch.

Survivors of Suicide Bereavement Support Association (SOBSA) providing support groups in a number of Queensland locations [www.geocities.com/sosbsa/](http://www.geocities.com/sosbsa/)


Living Beyond Suicide – Anglicare, SA, offers survivor-sensitive early support, information & resources for families bereaved through suicide [www.anglicare-sa.org.au/services/lbs.html](http://www.anglicare-sa.org.au/services/lbs.html)


Suicide Prevention Australia Position Paper on Suicide Bereavement & Postvention [suicidepreventionaust.org/PositionStatements.aspx#section-5](http://suicidepreventionaust.org/PositionStatements.aspx#section-5)
13.8.3 Canadian and American resources

Survivor Resources (Suicide Prevention Resource Center, USA)
www.sprc.org/featured_resources/customized/survivors.asp

“Suicide postvention is prevention: a proactive planning workbook for communities affected by youth suicide” BC Council for Families, 2005 www.bccf.bc.ca

“Grief after suicide”, Canadian Mental Health Association pamphlet, www.cmha.ca/bins/content_page.asp?cid=3-101-103&lang=1


Heartbeat; grief support following suicide “HEARTBEAT is a peer support group offering empathy, encouragement and direction following the suicide of a loved one” (USA) heartbeatsurvivorsaftersuicide.org/index.shtml

“To the newly bereaved after suicide”; by LaRita Archibald; 12 ways through “the anguish in the aftermath of a loved one’s suicide” www.heartbeatsurvivorsaftersuicide.org/materials/to_the_newly_bereaved_after_suicide.htm


SAVE: Suicide Awareness Voices of Education – Coping with Loss (USA) www.save.org/index.cfm?fuseaction=home.viewPage&page_id=FE01AC0F-E081-2F43-D40D845F9B82FFD0

SPAN USA (Suicide Prevention Action Network) See Survivors Support section www.spanusa.org

American Association of Suicidology – Suicide Loss Survivors' web pages including: The SOS Handbook, a booklet for suicide survivors, and Surviving Suicide newsletter www.suicidology.org/web/guest/suicide-loss-survivors


Centre for Suicide Prevention, Canada:

*Supporting Suicide Survivors www.suicideinfo.ca/csp/assets/alert38.pdf

*They might be grieving too: commonalities of the suicide grief experience www.suicideinfo.ca/csp/assets/alert59.pdf

Sibling Survivors resource website www.siblingsurvivors.com/

Baton Rouge Crisis Intervention Center, US based survivor resources www.brcic.org/

After A Suicide: Recommendations booklet for Religious Services and Other Public Memorial Observations www.sprc.org/library/aftersuicide.pdf (SPRC, USA)

Loving Outreach to Survivors of Suicide www.catholiccharities.net/loss/rubey Chicago based support and resources
13.8.4 United Kingdom resources


Survivors of bereavement by suicide [www.sobs.admin.care4free.net/#](www.sobs.admin.care4free.net/#) Survivors of Bereavement by Suicide (SOBS) is a self-help organisation to meet the needs and break the isolation of those bereaved by the suicide of a close relative or friend.

After someone dies: a leaflet about death, bereavement and grief for young people, Cruse Bereavement Care [www.rd4u.org.uk/YouthBooklet.pdf](www.rd4u.org.uk/YouthBooklet.pdf)

Survivors of Bereavement by Suicide self-help organization [www.uk-sobs.org.uk/](www.uk-sobs.org.uk/)

Cruse Bereavement Care (UK) [www.crusebereavementcare.org.uk/](www.crusebereavementcare.org.uk/) general grief & bereavement information & resources

Console [www.console.ie](www.console.ie) an Irish charity supporting and helping people bereaved through suicide

National Suicide Bereavement Support Network (Ireland) [www.nsbsn.org/](www.nsbsn.org/)

Healthtalkonline [www.healthtalkonline.com/Living_with_dying/Bereavement_due_to_suicide](www.healthtalkonline.com/Living_with_dying/Bereavement_due_to_suicide) Interviews of 40 people bereaved by suicide. Some have been bereaved recently, others years ago. Interviews tell of their experiences and the issues that affected them and where people found help.

US National Suicide Prevention Lifeline Gallery [lifeline-gallery.org/](lifeline-gallery.org/) Stories of hope and recovery from those who have lost someone to suicide – Go to Loss section of gallery and listen to personal stories of hope

13.8.5 Other international resources

International Association for Suicide Prevention (IASP) Postvention Taskforce [www.med.uio.no/iasp/english/postvention/postvention.html](www.med.uio.no/iasp/english/postvention/postvention.html)


An international clearing house of suicide bereavement related information, research & resources [www.bereavedsy Suicide.com](www.bereavedsy Suicide.com)
Appendices – Specific examples and templates

Appendix 1
The Rights of Suicide Survivors

From the Charter “The Rights of Suicide Survivors” Working Group on Suicide Survivors (Mäenpää 2003)

The survivor has the right:

1. To mourn in their own way and within the time it takes

2. To know the truth about the suicide, to see the body of the deceased, and to organise the funeral with respect to one’s own ideas and rituals.

3. To consider suicide as the result of several interrelated causes that produced unbearable pain for the deceased: suicide is not a free choice.

4. To live, wholly, with joy and sorrow, free of stigma or judgement.

5. To respect one’s own privacy as well as that of the deceased.

6. To find support from relatives, friends, colleagues, and survivors, as well as from professional helpers who have knowledge and insight in the dynamics of bereavement, potential risk factors, and in the practical consequences.

7. To be contacted by the clinician/caregiver (if any) who treated the deceased person.

8. To not be considered as a suicide candidate or as a patient.

9. To place one’s experiences in the service of other survivors, caregivers, and everyone who seeks to better understand suicide and suicide bereavement.

10. To never be as before: there is a life before the suicide and a life afterwards.
Appendix 2
Suicide Facts and Statistics

This section contains a brief overview of facts and statistics about suicide in Australia. The main source of Australian data on suicides is the Australian Bureau of Statistics (ABS). They release new data on an annual basis. Unless otherwise stated, the statistics provided in this document are from the ABS publication, *Causes of Death, Australia, Suicides 2007* (ABS Cat. No. 3303.0) (from Mindframe National Media Initiative [www.mindframe-media.info/site/index.cfm?display=85537](http://www.mindframe-media.info/site/index.cfm?display=85537)).

Definition of Terms
Terms that are commonly used when discussing suicide include:

**Suicide** — death as a result of self-inflicted harm where the intention was to die.

**Attempted suicide** — self-inflicted harm where death does not occur but the intention of the person was to die.

**Self-harm** — self-inflicted harm where death does not occur and the intention may or may not have been to die.

**Suicidal behaviour** — acts such as suicide and attempted suicide.

**Suicidal ideation/thoughts** — thoughts about, or plans for, taking one’s own life that may or may not lead to a suicide attempt.

A Note on Interpreting Suicide Facts and Statistics
Suicide statistics are usually reported as either the total number of persons who died by suicide or as an age-standardised suicide rate, such as 7 per 100,000 people. This means that for every 100,000 people in a population or sub-group, seven died by suicide in a given time period (usually a year). Suicide statistics may also be reported as a percentage of deaths from all causes, such as 2% of all deaths in a population were due to suicide. This means that for every 100 deaths in a population in a given time period, two were due to suicide.

Caution should be exercised when reporting and interpreting suicide information. The reliability of suicide statistics are affected by a number of factors including under-reporting, differences in reporting methods across states and territories, and the length of time it takes for Coroners to process deaths that are reported as potential suicides.

An Overview of Suicide in Australia
Several information papers produced by Auseinet may assist you to understand the available data about suicide and self-harm in Australia.

**Australian Suicide Statistics 2006 — Key findings**

**Australian Self-harm Statistics — Key findings**

How many people die by suicide in Australia?
- Suicide is a prominent public health concern in Australia. Over the past decade, about 1,900 people have died by suicide each year².
- There were 1881 deaths from suicide registered in 2007, which is slightly more than the 1,799 deaths from suicide recorded in 2006 but less than the 2,101 registered suicide deaths recorded in 2005.
- Deaths from suicide represented 1.4% of all deaths registered in 2007.
Is the problem getting worse?

- Suicide rates for both males and females have generally decreased since the mid-90s with the overall suicide rate decreasing by 37% between 1998 and 2007.
- Suicide rates for males peaked in 1997 at 23.6 per 100,000 but have steadily decreased since then and stood at 13.9 per 100,000 in 2007.
- Female rates reached a high of 6.2 per 100,000 in 1997. Rates declined after that and was 4.0 per 100,000 in 2007.

Do rates vary between states?

- Combining suicide data over a 5-year period provides a more reliable picture of differences across the states and territories due to the relatively small number of suicides in some states and territories in any one year.
- In recent years (2002–2007) Tasmania and the Northern Territory have had the highest rates of suicide, followed by South Australia. In contrast, New South Wales and Victoria had the lowest rates of suicide and the Australian Capital Territory and Queensland had fluctuating rates.

Are the rates different for males and females?

- Suicide rates for males are higher than those for females and have been higher since at least the 1920's; however, more women than men attempt suicide.
- The ratio of male to female suicides rose from 2:1 in the 1960s to over 4:1 in the mid 1990s. In recent years, the suicide rate for males has reduced slightly to just under the 4:1 ratio, and is consistent across most age groups.
- Between 1998 and 2007, the suicide rate fell by 37%, with this rate of change different for males (35%) and females (30%).

Do rates vary across age groups?

- From 1990 to 1997, 20 to 24 year old men were consistently the most likely of all age groups to die by suicide, with rates reaching 42.8 per 100,000 in 1997. However, between 1998 and 2005 the highest rates have been observed for males aged in the 25–44 year age groups. In 2007 the highest rate was observed in men aged between 35–39 years (although the rates are inflated by the small population) followed by the over 85 years age group.
- From 1990 onwards, there has not been any one age group of females that has consistently had a higher rate of suicide than other age groups.

Is there a youth suicide epidemic?

- The number of suicides among males aged 15 to 19 years has fallen considerably (more than halved) over recent years. In 1997, 121 males in this age group died by suicide (18.5 per 100,000). In 2007 69 males aged 15 to 19 died by suicide (9.3 per 100,000). This was slightly more than 2006 (8.8 per 100,000 or 64 deaths), but less than the decade to 2003.
- While the level of suicides among young females has been consistently lower than their male counterparts, the number of suicides observed for females aged 15 to 19 years in 2007 (27 suicides or 4.0 per 100,000) was substantially less than in 1997 (33 suicides or 5.3 per 100000). Further, the number of suicides observed for these females decreased somewhat between 2004 (32 suicides or 4.8 per 100 000) and 2005 (24 suicides or 3.6 per 100 000).
- Suicide in children under the age of 15 years is a rare event in Australia.
Are the patterns the same for Aboriginal and Torres Strait Islander Australians?

- Accurate suicide statistics and population estimates are difficult to obtain for Aboriginal and Torres Strait Islander people. Thus data on suicide levels and rates for Aboriginal and Torres Strait Islander people are likely to be, at best, minimum figures and the information must be interpreted cautiously.

- Due to both the relatively small numbers and low coverage in some areas of Australia, the ABS only publishes data on suicide deaths among Aboriginal and Torres Strait Islander people for New South Wales, Queensland, South Australia, Western Australia and the Northern Territory. In 2007, there were 89 deaths by suicide of Aboriginal and Torres Strait Islander people in the five states and territories considered, compared with 88 suicide deaths in 2006.

- The percentage of all deaths attributable to suicide is much higher among Aboriginal and Torres Strait Islander Australians (3.7% in 2007) than Non-Indigenous Australians (1.3%) in the specified states and territories.

- Suicide is more concentrated in the earlier adult years for Aboriginal and Torres Strait Islander Australians than for the general Australian population with 2003 data indicating the highest rates for both males and females being in the 15 to 24 year age group.

- As for other Australians, Aboriginal and Torres Strait Islander males are more likely to die by suicide than are Aboriginals and Torres Strait Islander females. Using combined data for 1998 to 2002, 6.7% of all male deaths were due to suicide compared with 1.9% of all deaths for females.

- Recent NT data shows significant increase in male Indigenous deaths since 1997.

Do rates vary among people from culturally and linguistically diverse backgrounds?

- Australia is home to people from a wide diversity of cultures. Suicide rates, and risk factors associated with suicide, differ between cultures.

- One quarter of suicides in Australia occur among people who have migrated to Australia, with 60% of these being people who have come from non-English speaking countries. However, rates vary according to country of origin, gender and age.

- Rates are generally higher among people born in English-speaking countries, and those from western, northern and eastern Europe, and lower among people from southern Europe, the Middle East and Asia.

- Overall, males born outside of Australia have a lower suicide rate than Australian-born males, while the rate is higher for females born overseas than for Australian-born females. The rate is also higher for people of both genders aged over 65.

Are rates higher in rural and remote Australia?

- There is some evidence that suicide rates in rural and remote areas are significantly greater than in urban populations. This may be especially true among young men in remote regions.

- Possible factors contributing to higher rates in these areas include isolation, rural poverty, increased risk-taking behaviour and access to lethal means. It has also been suggested that a culture of self-reliance, which does not encourage help-seeking behaviour, may be one of the most important contributing factors to youth suicide in rural areas.

Are rates higher in people who have mental illness?

- Many people who die by suicide or make a suicide attempt have a history of mental illness or are experiencing symptoms of mental illness.

- Up to 12% of people affected by mental illness take their own lives (compared with an average of 1.7% for the whole population), and suicide is the main cause of premature death among people with mental illness.

- Early detection and treatment of mental illness is important in preventing suicide, although many people do not seek help until symptoms become severe. This may be partly due to misconceptions and stigma surrounding mental illness.
Risk and protective factors for suicide

- Suicide is a complex phenomenon and rarely occurs as the result of a single event. Research has demonstrated that there are a number of risk factors and protective factors. Risk factors increase the probability of suicidal behaviour, while protective factors tend to offset that risk.

- Risk factors are categorised into individual, mental health, family, social and environmental risk factors. Individual risk factors include being male, experiencing psychological or emotional problems, physical health problems and stressful life events such as bereavement or relationship breakdown. Young gay or lesbian people may have an increased risk of suicidal behaviour.

- People with a mental illness are at increased risk of suicide, and may be especially vulnerable during exacerbations of their illness which require hospitalisation, after discharge from hospital or when treatment has been reduced. A history of mental illness and previous suicidal behaviour are also risk factors for suicide.

- Family related risk factors include family breakdown, family conflict, poor communication, child abuse and a family history of suicidal behaviour.

- Social risk factors include socio-economic disadvantage, school disengagement, unemployment, incarceration, isolation and living in a rural community. Suicide rates are also higher in some Aboriginal and Torres Strait Islander communities and in some migrant groups.

- Environmental risk factors include having access to methods of ending one's life. People may also be at higher risk if someone close to them has shown suicidal behaviour. Suicide sometimes occurs in 'clusters' within a local area, when people identify with the distress of someone who has died by suicide.

- Protective factors include a sense of connection with family, school or the community; the presence of a caring partner or family member; being responsible for children; problem solving skills; a positive coping style or strong spiritual or religious faith; economic security and good physical health. Early detection and treatment of mental health problems, as well as restricted access to means of suicide can also help to reduce suicide risk.

Myth Busting

There are many myths and misconceptions about suicide in the community. Below are suggestions for challenging some of these misconceptions using accurate information about suicide that has been drawn from research and clinical practice.

Most ‘normal’ people don’t think about taking their own life…

Measuring suicidal thoughts is difficult, but research suggests that thoughts about suicide are not that uncommon at some point in a person’s life, although most people do not act on them.

Most suicides occur without warning…

Although there may be some cases where suicide occurs without warning, many people that attempt or complete suicide give verbal or non-verbal clues before the incident. Often there has been a history of personal problems, warning signs, mental health issues, suicide threats or prior attempts. Many people thinking about suicide will tell someone, loved ones and/or strangers, and some will seek professional help.

If someone reveals their suicide plan, you should not break their confidentiality…

Any information suggesting a person is contemplating suicide should be acted upon. A serious threat of suicide is one of the few situations where confidentiality must be breached in the interest of saving a life.
People who talk about killing themselves or attempting suicide are not serious – talking about it is just an attention-seeking behaviour and should be ignored…

Any suggestion of suicidal thoughts or threats of suicide should always be taken seriously. A person who threatens or attempts suicide is in need of support, whether or not they may be serious about ending their life at that particular time.

Talking about suicide with someone who is at risk may give them the idea and increase the chances of an attempted suicide…

Actually, many troubled people may be relieved if the issue is raised in a caring and non-judgemental way, allowing them to talk one-on-one about their feelings and to seek help.

People who attempt suicide are just selfish or weak…

People who attempt suicide are often experiencing strong negative feelings, possibly as a result of a mental disorder and may believe there is no other solution. People in this situation need professional and personal support, not judgement.

References


3 Ibid


10 Ibid


13 Steel, Z., & McDonald, B. (2000). op cit


19 Ibid


Appendix 3
Toolkit for Helping Someone at Risk of Suicide

This toolkit has been produced by the Lifeline Information Service and can be viewed below or downloaded as a PDF file from the Lifeline Australia website at: www.lifeline.org.au/__data/assets/pdf_file/0020/14177/Lifeline_SuicidePrevention_Toolkit_Feb09.pdf

Tool Kit for helping someone at risk of suicide

Are you concerned that someone close to you is considering suicide?

Have you noticed changes in their attitude and behaviour?

Has someone you know attempted suicide?

Would you like to know how to help them keep safe?

It is distressing to realise that someone close to you may be considering suicide. This tool kit will help you identify signs to look for, decide what to do and learn what help is available.

Most people who consider suicide get through the crisis. Family, friends and professionals can make a big difference in helping people stay safe and re-establish reasons for living

Are you yourself thinking of suicide?

You are not alone. Thoughts of suicide occur to many people and for a range of reasons. The most important thing to remember is that help is available. Talking to someone is a good place to start, even though it may seem difficult. Approach a trusted friend or call one of the 24-hour numbers listed on the back page. Tell someone today!

Why does someone consider suicide?

Typically, many factors are involved. It is known that mental health problems, particularly depression, can increase vulnerability to suicide. Here are some clues about what to look for.

Situations — what's happening in the person's life?

Have they experienced any life changes recently?
  • Recent loss (a loved one, a job, an income/livelihood, a pet)
  • Major disappointment (failed exams, missed job promotions)
  • Change in circumstances (retirement, redundancy, children leaving home)
  • Mental disorder or Physical illness
  • Suicide of a family member, friend or a public figure
  • Financial and/or legal problems

Feelings — how does the person feel about it?

Events like the above can be difficult and sometimes devastating. Most people who experience them do not consider suicide, but some do. Be aware of:
  • How the person feels about what happened
  • What it means to them
  • Whether the pain feels bearable
Behaviours – what are they doing?

People at risk of suicide usually give clues by their behaviour. These may include:

- Previous suicide attempts
- Being moody, sad and withdrawn
- Talking of feeling hopeless, helpless or worthless
- Taking less care of themselves and their appearance
- Losing interest in things previously enjoyed
- Finding it hard to concentrate
- Being more irritable or agitated
- Talking or joking about suicide
- Expressing thoughts about death through drawings, stories, songs etc
- Saying goodbye to others and/or giving away possessions
- Engaging in risky or self-destructive behaviour
- Increasing alcohol/drug use

Mental Health

Mental health problems can increase the risk of suicide. We may not know a person’s mental health history, however we may notice that a person seems depressed or anxious, and/or is misusing alcohol or other drugs. They may have told us that they are receiving treatment for a mental health problem.

Having a mental health problem does not mean a person will have thoughts of suicide — many don’t. However, mental health problems can affect the way people view problems. They affect motivation and openness to seek help, therefore we need to be particularly aware of the possible risk of suicide.

People who have recently been discharged from hospital for treatment of mental health problems may also be at higher risk of suicide. It is important that they receive ongoing support in the community. You may be able to help by supporting them to attend any follow-up visits with their GP or mental health specialists.

What do I do now?

People considering suicide often feel very isolated and alone. They may feel that nobody can help them or understand their psychological pain. When unable to see any other way of dealing with pain, suicide may seem to be a way out. Sometimes people who have been distressed and openly suicidal become outwardly calm. Be aware that this may mean many things, including their quiet resolution to complete their suicide plan.

The important thing to remember is that if someone is not their usual self or if they are showing signs that arouse your concern you need to check it out. This tool kit will help you to talk to someone about suicide and then decide what steps to take.

Most people who consider suicide get through the crisis. The help and support of family, friends and professionals can make a big difference. The following tips will help you know what to do.
Tool Kit

1. Do something now

If you are concerned that someone you know is considering suicide, act promptly. Don't assume that they will get better without help or that they will seek help on their own. It's easy to avoid being part of that help, or to hope that someone else will step in. Reaching out now could save a life.

2. Acknowledge your reaction

When you realise that you need to take action to help someone who is considering suicide, your natural reaction may be to:

• Panic
• Ignore the situation and hope it will go away
• Look for quick-fix solutions to make the person feel better
• Criticise or blame the person for their feelings

These reactions are common but not helpful. It's natural to feel panic and shock but take time to listen and think before you act. Following the tips below will help you get through. If you find you're really struggling, enlist the help of a trusted friend.

3. Be there for them

Spend time with the person and express your care and concern. Ask them how they are feeling, hear their pain and listen to what's on their mind. Let them do most of the talking. Problems can seem more manageable after speaking about them.

4. Ask if they are thinking of suicide

Unless someone tells you, the only way to know if a person is thinking of suicide is to ask. Asking can sometimes be very hard but it shows that you have noticed things, been listening, that you care and that they are not on their own. Talking about suicide will not put the idea into their head but will encourage them to talk about their feelings. It opens up options for checking out risk, attending to safety and getting further help.

5. Check out their safety

If a person is considering suicide it is important to know how much thought they have put into it. Ask about the following:

• Have they thought about how and when they plan to kill themselves?
• Do they have the means to carry out their plan?
• Have they ever deliberately harmed themselves?
• What support can they access to stay safe and get help?
• How can you help them draw on links to family, friends, pets, religious convictions, personal coping strengths?

Use this information to decide what to do. If you are really worried, don't leave the person alone. Seek immediate help — see contact numbers below or phone Lifeline on 13 11 14. Remove any means of suicide available, including weapons, medications, alcohol and other drugs, even access to a car.
6. Decide what to do

Now that you have this information you need to discuss together what steps you are going to take. What you decide to do needs to take into account the safety concerns that you have. Do not agree to keep it a secret.

You may need to enlist the help of others to persuade the person to get professional help — or at least take the first steps to stay safe. These may include their partners, parents, or close friends. Only by sharing this information can you make sure that the person gets the help and support they need.

Sometimes the person at risk says they do not want help. Yet we know most people are in two minds about suicide. Make keeping them safe your first priority. Consider the long-term benefits of getting help for the person. It may mean risking the relationship but you could be saving a life.

7. Take action

The person can get help from a range of professional and supportive people:

- GP
- Counsellor, psychologist, social worker
- School counsellor, youth group leader, sports coach
- Emergency services — police and ambulance
- Mental health services
- Community health centres
- Priest, minister, religious leader
- Telephone counselling services such as Lifeline and Kids Help Line

When the person has decided who they are most willing to tell, help them prepare what they will say. Many people find it difficult to express their suicidal thoughts.

Offer to accompany the person to the appointment. After the appointment, check that they raised the issue of suicide and ask what help they were offered. Help them follow through with the recommendations.

In some situations the person may refuse to get help. While it’s important that you find them the help they need, you can’t force them to accept it. You need to ensure that the appropriate people are aware of the situation. Do not shoulder this responsibility alone.

8. Ask for a promise

Thoughts of suicide often return and when they do it is important for the person to again reach out and tell someone. Asking them to promise to do this makes it more likely that it will happen. Encourage the person to promise to call you or Lifeline 13 11 14 if the suicidal thoughts return and to do this before they harm themselves.

9. Look after yourself

If you’re helping someone who is considering suicide, make sure you also take care of yourself. It is difficult and emotionally draining to support someone who is suicidal, especially over an extended period.

- Don’t do it on your own. Find someone to talk to, maybe friends, family or a professional.
- Recruit other people to help support the person you are worried about.
- Get in touch with carer organisations or support groups. Contact Lifeline’s Just ask 1300 13 11 14 to find what’s available in your area.
• Try not to let your concerns about the other person dominate your life. Make sure you continue to enjoy your usual activities, take time out to have fun and keep a sense of perspective.
• Contact Lifeline on 13 11 14 (24 hours a day) for support.

10. Stay involved

Thoughts of suicide do not easily disappear without the person at risk experiencing some change. Their situation, or their feelings about it, may change, or they may feel more supported and able to deal with it. In either situation, the continuing involvement of family and friends is very important. Below are some tips to ensure the person at risk continues to get the best help possible:
• Ensure the person has 24-hour access to some form of support. This may be you, other family members and friends, or Lifeline 13 11 14.
• Accompany the person to appointments if possible. Your support can be a great encouragement.
• If you are the primary carer, try to establish a good relationship with the health professionals responsible for the person’s treatment. Your opinion and input is valid and may be very valuable.
• Advocate for the person. Sometimes a service or health professional may not be capable of meeting all the person’s needs. You can advocate for appropriate services.
• Discuss with the person what issues or situations might trigger further suicidal thoughts. Plan how to reduce this stress and what coping strategies can be used.
• Continue to be supportive but not overprotective.

Suicidal thoughts do not easily go away on their own. People need to see change in their life and they need help to achieve that change. You are part of that help.

Where to get help

For immediate crisis intervention when life may be in danger ring the police on 000 or go to your local hospital emergency department

24-hour crisis telephone counselling services:

National
Lifeline 13 11 14
Kids Help Line 1800 55 1800
Mensline Australia 1300 78 99 78
Salvation Army Hope Line for suicide bereavement support 1300 467 354

A.C.T.
Crisis Assessment and Treatment Team 1800 629 354

New South Wales
Suicide Prevention and Crisis Intervention 1300 363 622
Salvo Care Line 02 9331 6000
02 8736 3292 (Sydney)
Northern Territory
NT Mental Health CRISIS Services (Darwin) 08 8999 4988
NT Mental Health CRISIS Services (Alice Springs) 08 8951 7710

Queensland
Crisis Counselling Service 1300 363 622
Salvo Care Line (Brisbane area) (07) 3831 9016

South Australia
Mental Health Assessment and Crisis Intervention Service 13 14 65

Tasmania
Samaritans Lifelink – country 1300 364 566
Samaritans Lifelink – metro 03 6331 3355

Victoria
SuicideLine (Victoria) 1300 651 251

Western Australia
Samaritans Suicide Emergency Service – country 1800 198 313
Samaritans Suicide Emergency Service – metro 08 9381 5555

Services:
Your GP (see Yellow Pages for listing)
Mental Health Team (see Community Health Centres in the White Pages)
Counselling/Psychological Services (see Yellow Pages for listing)
Sane Australia help line 1800 688 382
beyondblue info line 1300 22 4636

Web sites:
www.livingisforeveryone.com.au An Australian government website providing information and building community capacity for suicide prevention
www.lifeline.org.au/find_help/service_finder – a large online national database of low cost or free health and community services throughout Australia
www.beyondblue.org.au – an Australian site with information on depression
www.depressionet.com.au – an on-line Australian resource on depression
www.kidshelp.com.au – a site offering telephone and email counselling for young people
Resources:

Beyond Suicide Attempts booklet – information for parents, foster parents and guardians following the suicide attempt of a young person. Available from Lifeline Information Service infoservice@lifeline.org.au

Survivors of Suicide – A compassionate resource developed to support people who have lost a loved one to suicide. www.readthesigns.com.au/get_help/support_after_a_suicide Available from the Lifeline Information Service infoservice@lifeline.org.au

Training:

ASIST – many Lifeline Centres throughout Australia provide LivingWorks Applied Suicide Intervention Skills Training (ASIST) if people are looking for further training in this area www.lifeline.org.au/learn_more/livingworks. Contact LivingWorks to find an ASIST training near you, 03 9894 1833 or info@livingworks.org.au
Appendix 4
Closed groups: example and rationale

Limited time group program – example of typical format

Jesuit Social Services: Building a Just Society (Support After Suicide Service, used with permission)

A group for those bereaved by suicide

Influences in the Development of the Group

- The bereaved. Listening, respecting, accepting the experience of the bereaved reveals much about what is needed
- Experience as practitioners
- Current literature, theory and research.
- Aims
- Receive information about suicide and the experience of suicide bereavement
- Gain a greater understanding of the unique issues and experiences associated with bereavement following suicide
- Spend time and communicate with others who have also been bereaved as a result of suicide
- Develop resources to assist with the experience.

Structure

- Psycho-educational approach
- Small number of participants — around 8
- One person per family/friends group in the support group
- 8 weekly sessions and the Friends and Family Session
- 2 hour sessions, with a break about halfway
- Two professional facilitators. Preparation and debriefing following each session.
- Between 3 and 18 months bereaved
- A closed group – no new participants after the first session
- Structure – open sharing of issues and experiences, specific theme for each group session
- Includes a reflection journal
- Each of the participants to meet at least once with a facilitator prior to the group. There is a need to screen and prepare participants for the group (see screening sheet)
- Evaluation (developed by SAS).

Session Topics

- Introduction
- Experience of bereavement
- Expression of bereavement
- Exploring changes
- Living memories
- Creative bereavement
• Self-awareness and self-care
• Grief across the life span

**Potential Topics for a Suicide Bereavement Support Group**

Some groups identify a focus/topic each meeting.

Here is a list of the topics used by one group throughout the year (Lifeline Mid-Coast, Port Macquarie, NSW)

<table>
<thead>
<tr>
<th>About Grief</th>
<th>Looking after yourself (meditation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altered Relationships</td>
<td>Losing a sibling</td>
</tr>
<tr>
<td>Anger, fear</td>
<td>‘Lostness’ and loneliness</td>
</tr>
<tr>
<td>Anniversaries and special days,</td>
<td>Making a difference</td>
</tr>
<tr>
<td>Children, Teenagers and grief</td>
<td>Memorial Service</td>
</tr>
<tr>
<td>Collage (about the person we lost)</td>
<td>Pain of loss</td>
</tr>
<tr>
<td>Continuing bonds</td>
<td>Photos, about the person</td>
</tr>
<tr>
<td>Coping with depression</td>
<td>Psycho-social transitions</td>
</tr>
<tr>
<td>Dinner</td>
<td>Resources</td>
</tr>
<tr>
<td>Family map</td>
<td>Rituals and memorials</td>
</tr>
<tr>
<td>Forgiveness</td>
<td>Spirituality</td>
</tr>
<tr>
<td>Guilt, anger</td>
<td>Stigma</td>
</tr>
<tr>
<td>Hope</td>
<td>Stress, anxiety</td>
</tr>
<tr>
<td>How we change with grief</td>
<td>Survival strategies</td>
</tr>
<tr>
<td>Isolation masks we wear</td>
<td>The Funeral (bring eulogy?)</td>
</tr>
<tr>
<td>Living with not having the answers</td>
<td></td>
</tr>
</tbody>
</table>

**Rationale for closed group programs for those bereaved by suicide: (Sands, D 2004)**

1. Many researchers concur that those bereaved by suicide experience a particularly complicated bereavement and that meaning reconstruction is a central process in grieving. The process of meaning reconstruction is significant in suicide bereavement due to the complex and difficult issues provoked by a suicide death.

2. The closed group program is premised on research that the role of the professional in grief support is not only assisting people through grief processes shaped by nature but actively intervening to assist the bereaved to:

   a) Shape positive meanings that govern their grief experience and improve grief outcomes.

   b) Facilitate verbal and non-verbal conversations that assist in building trust, relational connection and intimacy to support complex meaning reconstruction processes.

3. The closed group program provides lengthy, ongoing education and support over six months that assists participant development of the group as a safe, legitimate communication space for social interactions to process suicide grief issues, this is often not available to the bereaved in their own relational networks.

4. Grieving is a learning process and continuity and sequential time is required for integration of learning and the introduction of appropriate interventions.
5. Hope is nurtured as group participants witness their own, and other participant grief narrative shifts, and value their role in supporting this process.

**The closed group**

- Professionally facilitated and psycho-educational
- Range of active interventions specifically for suicide bereavement based on research and best practice
- Intake meeting — suicidality assessment and contract
- Information session prior to commitment to join
- 8–12 participants
- Same participants attend each session
- 10–12 sessions fortnightly over 6 month period
- Each session 3 hours
- Flexible structure to meet needs of group participants
Appendix 5
Examples of Group Ground Rules

Guidelines for Survivor Support Group Participants – HEARTBEAT
(excerpt from AAS Surviving Suicide, V 2, No. 2, Summer 1990, used with permission)

Survivors of suicide groups provide participants with an experience of healing and community with other survivors. In addition, it gives participants an opportunity to join in a process which leads to comfort, support and information exchange. We believe that this is best done in the non-confronting small group format which encourages participation of all members and maximizes the potential of each member to contribute meaningfully to the process. To that end, we suggest the following guidelines:

1. Adults learn best by hearing experiences of others, not by getting advice from others. Therefore, it is usually best to say what YOU did in a similar situation, rather than what someone else SHOULD do.
2. Inquire to learn more about something. Don’t put anyone on trial or try to point out the faults in someone else’s thinking or actions.
3. Respect the opinions and experience of others. What doesn’t work for you may work for someone else.
4. Share even if you were unhappy about the outcome of some action. It might help someone else avoid your mistakes.
5. Be respectful of the grief of others. Don’t interrupt.
6. Share the time available in the group. Don’t monopolize.
7. Don’t expect others to solve your problems or give you advice.
8. Be open to help from people other than the leader.
9. The information about themselves which participants share in groups, whether small groups or large, is CONFIDENTIAL.
10. Give yourself a chance. If the first meeting doesn’t do it for you, come back at least two more times before deciding that you are better off elsewhere or alone.
11. Newly bereaved attend to have the magnitude of their grief acknowledged and validated; to be comforted, encouraged and shown the way; even newcomers bring something unique the group. Listen!
12. Get involved by volunteering to help with group work.

Ground Rules for Self-Help Support Groups
Jon Stebbins (used with permission)

Here is a suggested statement outlining the “ground rules” we suggest best reflect our belief at The Compassionate Friends on how the best learning/growing support can be facilitated. It reflects the qualities of empathy, respect, and genuineness towards participants.
About our Sharing:

First let me emphasise:

Tonight is for you – to use as you feel able. Our task as leaders is to set up a supportive atmosphere & the opportunity for you to share:

- Where you are at this stage in your difficult journey to build a new life
- Any issues you are faced with & would like to discuss

Furthermore:

- You may share as little or as much as you feel able to. Sharing or being silent – both are OK.
- Feel free to contribute at your own pace.
- Tears are OK – they show that you cared very much for your loved one, and that you care for yourself.
- And some of you may have some energy left over to cry with and show a little caring for others. But don’t be too hard on yourself if your pain is still too great to go outside yourself and feel for others. It will come with time.

Four additional things from us; we call them ground rules, but they are just reminders:

- That help us support each other better,
- That keep us aware that our time tonight is limited, and
- That remind us about the best way to share and help each other

Firstly, it takes courage to come here, and to speak about ourselves. So can I ask that we all listen when someone is speaking, and try to be aware when someone is just pausing and needs silence and time and space before continuing to speak? Can I suggest something else in relation to listening that you may be well aware of? That is, that what we are most looking for in our struggle is listening and understanding, and rarely do we need advice. If we do we usually ask directly for it. So be wary about jumping in with advice and suggestions.

Secondly, we are not here to rescue each other, but to listen and to support each other to regain confidence in using our strengths. Distressing though it may be, we need to express and feel our pain. Unless we are “with” our pain, we cannot learn to walk beside it. So someone who is distressed and crying is actually doing something very positive. They are learning to handle their pain. The best support we can give is to listen, and encourage them to talk about their feelings and experiences.

Thirdly, I know our own needs are often very strong and we get wound up with the need to express and talk about them. However time is limited, and so we ask your permission for us to say “we must move on” if it becomes necessary. Is that OK?

Fourthly, the issue of confidentiality. We ask you to keep what is shared tonight within the group. Some of us don’t care who knows our story, but some of us are private people and will feel more comfortable and more confident about sharing if we know that what we share will remain private in this group. Also we will inevitably be talking about other people who are not here (our children, other family members, friends, professionals, etc.), and their privacy also needs to be respected.
Appendix 6
Example of a Screening and Preparation Tool

Jesuit Social Services: Building a Just Society
(Support After Suicide Service, used with permission)

Screening and Preparation for Group Participants
[Note: This is for a closed, time-limited support group]

1. Screen for major mental illness and substance use issues which may affect appropriate participation in the group.

2. Screen for readiness for group participation:
   - Ability to listen to others
   - Capacity to hear others’ pain
   - Some diminishment of trauma response
   - Some capacity to express own experience
   - Capacity to commit to the 8 sessions
   - Other concurrent losses/crises.

3. Consider other support and counselling needs of the participant

4. Consider length of time bereaved:
   - Between 3 and 18 months: it can work to extend these timelines but preferably there will be only one participant under 3 months (and only if they are ready for group participation) and there is a range of other participants in terms of time since bereavement.

5. Consider compatibility with other group participants:
   - Age and gender
   - Relationship with deceased

6. Preparation
   - Explore practicalities to enable group participation, e.g. child-care, meal preparation, support person available
   - Explore self-care before and after the group sessions
   - Provide information about the format and structure of the group
   - Provide general information about the other participants, e.g. other parents, partners
   - Prepare participants for the experience of the group: the group is effective and helpful, however, some people may find the first couple of sessions difficult. The group is an effective opportunity to explore bereavement experience and gain support but it can at times be difficult. This changes/eases as the group progresses.
Appendix 7
Example of meeting reminder card

(Archibald, 2007, used with permission)

Dear Friend

We missed you at our (month) meeting. We hope your absence was due to an activity reinforcing to you and your family.

Our next meeting is at (time), (date) at (location).

If you have need of our support please come, we have much to offer you.

If you have moved beyond this need, please return occasionally, for you have much to offer others.

(Facilitators name)
Appendix 8
Example of selection criteria for a SBSG facilitator/coordinator

Draft Position Description Lifeline SBSG Facilitator/Coordinator

Position Criteria

Commitment
- To the aims and objectives of the SBSG Project
- To Lifeline Australia’s core values, vision and mission
- To the health, safety and wellbeing of self, co-facilitator and group participants

Qualifications & Training
- Formal qualifications in welfare, social work or counselling (highly desirable)
- Training in Group-work
- Training in Loss & Grief
- Training in suicide first aid (completion LivingWorks ASIST in the past 2 years, or refresher Tune-Up)

Specific Knowledge and Skills
- Highly skilled and trained in Suicide Prevention and intervention
- High level of skill in group work
- High degree of knowledge relating to Loss and Grief
- Excellent understanding of suicide bereavement and the potential complications of grief
- Understanding of mental health implications of trauma, loss, grief and suicide
- Excellent management, leadership and organisational skills
- High level of communication skills — written, verbal and interpersonal.
- Intermediate internet and computer skills
- Sound knowledge, experience and understanding of counselling process
- Able to give and receive constructive and effective feedback
- Understanding the value of supervision
- Awareness of available community support networks and pathways to care
- Cultural safety practices
- Strategies for self-care

Experience
Essential
- Experience with group work (essential)
- Experience of working in suicide prevention or crisis support services (essential)
- Minimum 3 years experience in either counselling, social work, welfare, loss & grief work (essential)
Appendix 8 Example of selection criteria for a SBSG facilitator/coordinator

Desirable

- Lifeline experience (desirable)
- Experience in supporting people bereaved by suicide (desirable)
- Project management (desirable)
- Experience with loss & grief issues (desirable)
- Group co-facilitation experience (desirable)
- Experience with specific modality of group e.g. tele-group if interested in that modality (desirable)

Personal qualities

- Empathic, compassionate, respectful, non-judgemental, empowering, affirming, consistent, calm under stress
- Trustworthy, honest and open
- Confident and competent
- Able to keep confidences (unless someone is ‘at risk’)
- Approachable and willing to be available to group participants on a flexible basis
- Able to build rapport with, and understanding of, people bereaved by suicide
- Able to contribute to positive morale
- Strong teamwork focus
- If personally bereaved by suicide, sufficiently integrated own bereavement and able to keep that experience in the background and the issues of the group members in the foreground
- Ethical, with a clear sense of personal and professional boundaries
- Aware of the possible effects of own beliefs, behaviour and appearance on others
- Culturally considerate
- Non defensive and able to use constructive criticism effectively
- Recognise own limitations

Duties and Responsibilities

Informed by SBSG Standards, Facilitator Practice Handbook and MOU

- Coordinate and facilitate SBSG Trial (SBSG)
- Attend 3.5-day SBSG facilitator training provided by Lifeline Australia with co-facilitator
- Promote trial SBSG in trial community
- Communicate with relevant agencies/organizations to solicit group membership
- Provide a contact point for inquiries/requests to the Centre regarding SBSG
- Follow-up enquiries from those referred to SBSG (within the shortest possible time)
- Pre-interview/assess potential group members for fit
- Communicate group meeting details with group members
- Regular group meeting preparation: planning and designing support group sessions and debrief with co-facilitator
- Develop contingency plan for unexpected absence of facilitator
- Develop exit strategies for members needing to leave the support group
- Develop strategy for ending the group and aftercare
• Facilitate all meetings with co-facilitator according to the training, standards and best practice guidelines
• Adhere to the Code of Ethics (refer Standard 1.4)
• Ensure members are familiar with the group guidelines (refer Standard 1.4)
• Ensure members know about 24 hour contact supports
• Ensure new members feel comfortable and safe
• Provide direction in structured information sessions
• Continuously adhere to the ‘Above all, do no harm’ principle
• Monitor and respond to potential suicide risk of members
• Ensure cultural safety
• Follow-up clients between meetings as required
• Provide referrals for group members as required
• Attend regular supervision with Mental Health professional
• Manage self-care strategies
• Fulfil all reporting requirement for trial as stated in MOU
• Fulfil all evaluation requirements for trial as stated in MOU
• Participate in regular communication with other centre SBSG Facilitator/Coordinators and Lifeline Australia as stated in MOU
• Maintain confidential records pertaining to the trail and provide information to management as required as stated in MOU
• Ensure boundaries and limitations of trial are consistently observed as stated in MOU and Standards
• Communicate regularly with Centre management regarding activities of SBSG trial as stated in MOU
Appendix 9

Suicide in the Media
(www.mindframe-media.info/mentalhealth)

Whether to participate in the story
Avoid participating in repetitive, prominent or excessive reporting of suicide. Will the story increase community understanding of suicide? If so, are you the most appropriate person or organisation to provide comment?

Provide support information
Provide media professionals with help line numbers and information about available treatment and support. Suggest that this information is included to provide support for those who have been distressed by the story.

Avoid description of the suicide
Avoid discussing details of method and location and suggest the exclusion of this information from stories wherever possible. Detailed description of a suicide death can prompt some vulnerable people to harm themselves.

Use appropriate language
Check that your language does not sensationalise suicide or present it as an option for dealing with problems – e.g. use ‘non fatal’ rather than ‘unsuccessful’, ‘took their own life’ or ‘died by suicide’ rather than ‘successful suicide’ or ‘committed suicide’ and use statements such as ‘cluster of deaths’ rather than ‘suicide epidemic’.

Place the story in context
Place stories in context by providing general information about suicide and its relationship to mental illness and other risk factors. Avoid simplistic explanations that suggest suicide might be the result of a single factor or event.

Interviews with people bereaved by suicide
People bereaved by suicide may be at risk of mental health problems or self-harm. Caution should be exercised when providing media access to these people.

Mental Illness in the Media

Whether to participate in the story
Consider whether the story has the potential to contribute to community understanding of mental health and mental illness. If so, are you the most appropriate person or organisation to provide comment?
Provide support information
Provide media professionals with help line numbers and information about available treatment and support. Suggest that this information is included to provide support options for people who may have been prompted by the story to seek help.

Use appropriate language
Be aware of your own language and suggest alternatives to any unhelpful phrases used by media. Avoid terms such as ‘deranged’, ‘mental patient’ or ‘psycho’. Do not refer to someone as ‘a victim’, ‘suffering from’ or ‘afflicted’ with mental illness. Do not label people with their illness e.g. a person is ‘living with’ or has a ‘diagnosis of schizophrenia’, they are not a ‘schizophrenic’. Ensure that medical terminology is used correctly and in context.

Avoid negative stereotypes
Be mindful not to reinforce stereotypes such as those that link mental illness with violence or suggest people are unable to work, parent or lead fulfilling lives.

Where possible provide information to counter these stereotypes, presenting a balanced view of people who have a mental illness.

Consumer and carer involvement
Consumers and carers considering talking to the media should have access to appropriate support throughout the experience and an opportunity to debrief afterwards. Encourage those considering media involvement to ask questions of journalists before making a decision.

In all verbal and written communication, refer journalists to the Mindframe website at www.mindframe-media.info for reporting issues and links to resources.

The above suggestions are a summary of those in the resource book Suicide and Mental Illness in the Media: A resource for the Mental Health Sector, available at www.mindframe-media.info/mentalhealth

Working with the Media

When the media calls
Find out about the story/interview:
• Who is the journalist?
• What is their knowledge/opinion of the issue?
• Who else are they speaking to?
• Who do they want to interview?
• When do they want to do the interview?
• What is the story about?
• What is the reason for the story?
• What information will be required?
• What types of questions will be asked?
• Is it for radio, television or print media?
• Is it for a news story, feature, other?
• Will pictures/video be required?
• When will the story be published/broadcast?
Refer the journalist to the Mindframe website for information about reporting issues
- Give a response within the agreed deadline
- Remember that it is OK to say no
- Follow the procedures in your media policy
- Be clear about the areas you are able to comment on and stick to these
- Identify spokespeople and make sure they are well briefed and familiar with the Mindframe principles
- Collect relevant facts and statistics and helpline numbers to support the story

When you are seeking media coverage

Make sure your story is ‘newsworthy’
- Do you have something new to say, new data or trends to show change?
- Is it an issue that will affect the lives of the audience, or that the audience may relate to?
- Does it relate to an issue currently in the media?
- Emphasise one of these aspects in your approach — this is your ‘angle’
- Be prepared to follow up on any story you pitch:
  - Prepare background information
  - Line up spokespeople for interview
  - Identify photograph or video opportunities
  - Be clear about what you can and can’t provide

Preparing a media release

To catch attention use a short clear heading that highlights the most important point.
- Summarise the main points in the first paragraph.
- In one to two sentences outline who, what, where and when and if possible why and how.
- Keep it to one page and use short sentences and simple language.
- Include contact details for people who can provide further information at the bottom of the release.
- List the Mindframe website at the bottom of the release.
- Use letterhead if available and use double spacing (or 1.5) between lines of text.
- Fax or email the release and follow up with a phone call.

Interviews

Be prepared
- Know your subject and organisation well.
- Be clear about your message.
- Identify three main points that you want to get across. It may be useful to write these on a card to refer to during the interview.

During an interview
- Keep your message simple.
- Use short sentences and avoid jargon.
- Stick to your subject.
• Don’t say anything you don’t want reported.
• Instead of saying ‘no comment’ give a reason why you are unable to answer the question, e.g. ‘That is out of my area of experience’.
• In an interview is about a crisis, do not give extra information that may worsen the situation.
• Keep coming back to your three main points.

For more information on working with the media go to the mental health section of the Mindframe website at: www.mindframe-media.info/client_images/574273.pdf
Appendix 10
Examples of Feedback Questionnaires for Group Members

Example 1
ALICE SPRINGS BEREAVED BY SUICIDE SUPPORT GROUP
(used with permission)

EVALUATION [month or date]

1. What did you expect to gain from attending this group?
2. Do you think these expectations have been met?
3. How has this group helped you?
4. Has it been difficult for you to attend this group? If so, why and if not, why not?
5. Do you have any suggestions for the facilitators of the group, e.g. new ideas, guest speakers or techniques?
6. Would you like to contribute to the area of suicide bereavement in other ways? If so, please nominate, e.g. co-facilitating a session, promotion, guest speaker at relevant forums, assistance with a special event, etc.
7. Do you have any other comments to make about the support group?

Example 2
SUPPORT AFTER SUICIDE

Support Group
Participants Evaluation Form
(used with permission)

We would like to know whether you found the group helpful in managing your bereavement and how we could improve it for future participants. Please tick one column to indicate your response to each statement. Thank you.

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Disagree Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt the group understood my experience of bereavement</td>
<td></td>
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<td></td>
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<tr>
<td>I felt the leaders understood my experience of bereavement</td>
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<tr>
<td>The group gave me enough the opportunity to express my thoughts and feelings</td>
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<tr>
<td>The leaders gave me enough opportunity to express my thoughts and feelings</td>
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<tr>
<td>I found at least one person in the group with whom I would like to keep in touch</td>
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<tr>
<td>Strongly agree</td>
<td>Agree</td>
<td>Neither agree nor disagree</td>
<td>Disagree</td>
<td>Disagree strongly</td>
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<tr>
<td>I found that the other group members thought and felt as I did</td>
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<tr>
<td>I felt part of the group</td>
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<tr>
<td>In the group I have asked questions that I was unable to ask before</td>
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<td>In the group I was able to say things that I was unable to say before</td>
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<tr>
<td>I understand more about my reactions to bereavement now</td>
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<tr>
<td>The group has given me confidence in speaking to others</td>
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<tr>
<td>I find it easier to get up in the morning and face the day</td>
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<td>I am now finding it easier to plan my daily activities</td>
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<tr>
<td>I am now more confident performing tasks that I did not have to do before</td>
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<tr>
<td>I feel more confident making decisions</td>
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<tr>
<td>I feel more able to manage my bereavement</td>
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<tr>
<td>I know what resources are available to me to assist with my bereavement</td>
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<tr>
<td>The group has helped me understand that my responses to bereavement are normal</td>
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</table>

Since attending the group have you noticed any changes in yourself?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What, if any, other topics would you have liked covered in the group?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Appendix 10 Examples of Feedback Questionnaires for Group Members

Which session of the group was most helpful and why?

__________________________

__________________________

__________________________

Which session of the group was least helpful and why?

__________________________

__________________________

__________________________

Please comment on the group facilitators.

__________________________

__________________________

__________________________

What are the most important things you are taking with you from the group?

__________________________

__________________________

__________________________

We greatly appreciate your comments and will use them to further develop the group for those bereaved by suicide. Thank you.
Appendix 11
Examples of SBSG Brochure

Brochure from Lifeline Hobart below — used with permission.
Also, Sutherland Shire Support After Suicide brochure located at
Example of input that might be useful in a brochure to introduce people to the idea of a group

**Introduction to Support Groups**

It can be so powerful to connect with other survivors; and such a relief to be able to talk openly about suicide with people who really understand.

For so many survivors, a crucial part of their healing process is the support and sense of connection they feel through sharing their grief with other survivors. The most common way this sharing occurs is through survivor support groups. These groups provide a safe place where survivors can share their experiences and support each other.

It is natural to feel a bit unsure about going to your first support group meeting. In “No Time to Say Goodbye”, one facilitator explains what you can expect:

> We sit in a circle, with each person giving a brief introduction: first name, who was lost, when it was, and how it happened. I then ask the people who are attending for the first time to begin, because they usually have an urgent need to talk. The rest of the group reaches out to them by describing their own experiences and how they are feeling. The new people realize they are not alone with their nightmare. By comparing their situations with others, they also begin to understand that they don’t have a monopoly on pain.

Some survivors attend a support group almost immediately, some wait for years; others attend for a year or two and then go only occasionally – on anniversaries, holidays, or particularly difficult days. You may find that it takes a few meetings before you begin to feel comfortable. Or, you may find that the group setting isn’t quite right for you, but can still be a useful way to meet one or two fellow survivors who become new, lifelong friends based on the common bond of understanding the pain and tragedy of suicide loss.

Reprinted from “Surviving a Suicide Loss: Resource and Healing Guide”, American Foundation for Suicide Prevention (AFSP) [www.afsp.org](http://www.afsp.org/)
Appendix 12
Code of Ethics for Group Facilitators

(Note: These Codes are not SBSG specific but are general in nature.)

The Institute of Group Leaders (www.igl.org.au) has the following Code of Ethics:

"Group leaders agree to:

1. keep and protect the confidentiality of group members by clearly defining what it means, why it is important and the risks and difficulties involved in its enforcement
2. only self-disclose information about themselves that develops the purpose of the group further rather than addressing any personal need of the leader
3. respect and encourage the voluntary participation of group members so as to promote and not delay their independence
4. behave professionally at all times and not become personally involved with any individual group member for the duration of the group
5. refrain from imposing their personal agendas and values on group members
6. only record or observe group sessions with permission of the group members and the leader’s organisation where applicable
7. only use a special technique or intervention if sufficiently trained or experienced in its use
8. provide information to group members about special techniques or activities in which they are expected to participate
9. respect the aims, values and methods of organisations for which they lead groups
10. access and participate in regular supervision as required for the type of groups they facilitate"

International Association of Facilitators


Statement of Values

As group facilitators, we believe in the inherent value of the individual and the collective wisdom of the group. We strive to help the group make the best use of the contributions of each of its members. We set aside our personal opinions and support the group’s right to make its own choices. We believe that collaborative and cooperative interaction builds consensus and produces meaningful outcomes. We value professional collaboration to improve our profession.

Code of Ethics

1. Client Service

We are in service to our clients, using our group facilitation competencies to add value to their work.

Our clients include the groups we facilitate and those who contract with us on their behalf. We work closely with our clients to understand their expectations so that we provide the appropriate service, and that the group produces the desired outcomes. It is our responsibility to ensure that we are competent to handle the intervention. If the group decides it needs to go in a direction other than that originally intended by either the group or its representatives, our role is to help the group move forward, reconciling the original intent with the emergent direction.
2. Conflict of Interest
We openly acknowledge any potential conflict of interest.

Prior to agreeing to work with our clients, we discuss openly and honestly any possible conflict of interest, personal bias, prior knowledge of the organisation or any other matter which may be perceived as preventing us from working effectively with the interests of all group members. We do this so that, together, we may make an informed decision about proceeding and to prevent misunderstanding that could detract from the success or credibility of the clients or ourselves. We refrain from using our position to secure unfair or inappropriate privilege, gain, or benefit.

3. Group Autonomy
We respect the culture, rights, and autonomy of the group.

We seek the group’s conscious agreement to the process and their commitment to participate. We do not impose anything that risks the welfare and dignity of the participants, the freedom of choice of the group, or the credibility of its work.

4. Processes, Methods, and Tools
We use processes, methods and tools responsibly.

In dialogue with the group or its representatives we design processes that will achieve the group’s goals, and select and adapt the most appropriate methods and tools. We avoid using processes, methods or tools with which we are insufficiently skilled, or which are poorly matched to the needs of the group.

5. Respect, Safety, Equity, and Trust
We strive to engender an environment of respect and safety where all participants trust that they can speak freely and where individual boundaries are honoured. We use our skills, knowledge, tools, and wisdom to elicit and honour the perspectives of all.

We seek to have all relevant stakeholders represented and involved. We promote equitable relationships among the participants and facilitator and ensure that all participants have an opportunity to examine and share their thoughts and feelings. We use a variety of methods to enable the group to access the natural gifts, talents and life experiences of each member. We work in ways that honour the wholeness and self-expression of others, designing sessions that respect different styles of interaction. We understand that any action we take is an intervention that may affect the process.

6. Stewardship of Process
We practice stewardship of process and impartiality toward content.

While participants bring knowledge and expertise concerning the substance of their situation, we bring knowledge and expertise concerning the group interaction process. We are vigilant to minimize our influence on group outcomes. When we have content knowledge not otherwise available to the group, and that the group must have to be effective, we offer it after explaining our change in role.

7. Confidentiality
We maintain confidentiality of information.

We observe confidentiality of all client information. Therefore, we do not share information about a client within or outside of the client’s organisation, nor do we report on group content, or the individual opinions or behaviour of members of the group without consent.
8. Professional Development

*We are responsible for continuous improvement of our facilitation skills and knowledge.*

We continuously learn and grow. We seek opportunities to improve our knowledge and facilitation skills to better assist groups in their work. We remain current in the field of facilitation through our practical group experiences and ongoing personal development. We offer our skills within a spirit of collaboration to develop our professional work practices.
Appendix 13
Example of a SBSG Newsletter

November/December 2008 Newsletter from NSW Dept of Forensic Medicine
Support After Suicide Group (used with permission)

You are not alone—shared experiences connect us
No 54
November/December 2008

Support After Suicide Newsletter

Welcome...

The abrupt ending of a life by suicide leaves unique emotional scars on those left behind. This newsletter aims to provide a link with others who have lost a relative, partner or close friend as a result of suicide.

Some of you may decide to attend group meetings where you will meet others who have suffered a similar loss. Some of you may never be able to do that, but have had some contact with one of the DOPM counsellors.

We hope that this newsletter will provide you with useful information and some comfort in knowing you are not alone.

Preparing for Christmas

For many bereaved people there is an incredible yearning and sadness that can intensify around Christmas. The realities of their new life without the presence of their loved one can be painfully obvious at this time when the emphasis is on spending time with family and close friends. Often the community is giving a message that all feelings of grief and loss should be put aside at this time, lest you spoil it for everyone else. Yet most people cannot simply shake off their grief and nor should they try. The enforced joyfulness can add even more stress and difficulty.

So what can we do help ourselves survive the pressures associated with Christmas and the holiday season?

Firstly, keep your life as simple as possible. Remember that you are particularly vulnerable at this time as your emotional, physical and mental capacities are already stretched. It is not the time to take on additional stress.

Secondly, plan ahead. Make time for what is important to you and allow yourself to escape some activities. Rehearse a simple explanation of why you may not attend some functions and limit your time spent with people who leave you feeling drained.

Discuss Christmas well in advance with the people you normally spend the day with.

Thirdly, think about what you have done in the past and consider what you think may work for you now. Sometimes this may involve a family discussion, or it may mean you decide to do something on your own that has a particular meaning for you. Maybe old ways of celebrating can be adapted so that they are comforting for you (such as including a special decoration to hang on the tree or lighting a special candle to burn during the Christmas meal). Other times, you need a complete change to help you and you may even consider going away for the holiday period as new places and people can help you to survive, particularly the first Christmas. NALAG (National Association of Loss And Grief) have some practical suggestions for coping with grief at Christmas which can be downloaded from: www.nalag.org.au/pubs/Coping_at_Christmas.pdf
Reach Out Australia, for young people, also has some suggestions which can be downloaded:


Lastly recognise that each year will be different and that how you want to spend this Christmas may not be what you want to do next year. Take each year as it comes!
A Lifeline
(reprinted from SAS Newsletter, No. 37, Jan/Feb 2006)

On 21st October, 2002, my 17 year old daughter ended her life, suiciding by hanging. No previous life experiences prepared me for the long and isolating journey I had now begun. My first interaction with the counselling team at Forensic Medicine, Greta, came the afternoon after her death. I remember a kind, caring and supportive counsellor arranging a viewing of my daughter’s body. It was at this time that the Support After Suicide Group was mentioned to me. Those first few weeks were spent in numb shock, only to be followed by such intense grieving. During this time I learnt what being a survivor of suicide meant. Sadly, our society finds suicide an unmentionable subject, so friends and colleagues went to great lengths to avoid any conversation about my daughter or what I was feeling. I was told that I had become resigned to her death, yet I had not. At a time when I was trying to work out what went wrong, when I needed to talk about her life and suicide, I found I had almost no one who would listen, that was until I attended my first Support After Suicide meeting.

This was their Christmas meeting and I remember surviving, observing people laughing. I couldn’t understand at that stage how anyone surviving suicide could ever laugh again, but the need was planted that if they could, so maybe could I. I shared with members the feelings I was experiencing and found I was not alone. On the first Tuesday of every month I felt a connection to people. I was no longer isolated on an island, watching the rest of the world go by, whilst mine had stopped. I left each meeting feeling like a soothing salve had been applied to my bleeding and dying soul.

At the meetings I shared my emotions, my difficulties at work, my grief that was so intense that I physically hurt, how I couldn’t stop bawling whoever ran this show called life to let me have my daughter back and how I had forgotten what happiness felt like. I had better months and I had horrible months where I sobbed throughout the meetings. During these bad periods, I was able to draw strength from the members, who only at the previous monthly meeting were needing support and encouragement. Even though I did not feel like things would get better, I would look at these people and think that like them, I too would come through the intensely emotional times.

It was at the support group that I learnt that it was OK to laugh again. Initially after my daughter’s death I felt that if she could not laugh, then how could I. This feeling was intensified by the misunderstanding of people in general that if I did laugh then that was a sign that I had moved on, gotten over the death. Laughing is the group, and we do laugh and joke, come with the unconditional understanding that this did not mean that we were grieving any the less or had ‘moved on’. Several of us would arrive early, just to share time with new friends and to have a laugh, but when the meeting commenced and everyone shared with the group who they had lost to suicide you could see the pain and loss that we all shared. That duality of emotion was important, as learning to feel normal, more like your old self is a terrifying thing. It does not come guilt free, as it is wrapped up in emotions of if I begin to function again am I still loving my child as much as I should. For someone outside of the group to give me permission to enjoy myself means nothing, and in truth was met with a wall of resistance from me, as how could they possibly know what was right for me, if they had not experienced this for themselves. But, if the same message was given by members of the support group then that meant something, as they knew exactly where I was at. This became my safe and supportive environment in which I learnt to function again in a more normal way.

Hearing the stories of other parents whose child had suicided allowed me to begin to forgive myself as I realised that they were like me, ordinary people who had dealt with extraordinary circumstances, that had led them to the death of their child. Over the months as I met parents who were good and generous people, I slowly began to stop beating up on myself and accepted that I too had done my best.

The group probably helped me avoid hitting someone. I would become so incarcerated at some of the stupid, name and often times cruel things people would say, and found it difficult to forgive such hurtful occurrences. I became aware of some people’s perception that if your child suicided, then there must have been something wrong with your parenting, or with you. I had no difficulty blaming myself for the outcome of my daughter’s life, and so at a time when I needed reassurance that I had done my best, I received the implicit message that I had let my child down. The principal of the school I taught at when my daughter committed suicide, told me 2 weeks after her death that I was lucky, as she had always been difficult (she was Bipolar) and that now I had all this money to spend on myself. When I would talk about these things, other members would share their experiences and how they handled it. Little did I realise that by talking about such things and sharing others who were further along the journey than I, the seeds of forgiveness had begun to be planted in me.

The counsellors at Forensic Medicine are incredible. They never try to tell us that they are the experts in surviving suicide, yet I have to tell them, they are. They acknowledge that it is the members who support each other and who
A Lifeline (cont’d)

have a better understanding. I believe they sell themselves short. They are aware of there being no set time line for a person grieving suicide, they are aware of the latest research in this area, and are able to share suggestions to help us in facing the difficult issues we raise.

The monthly newsletter always covers a different topic such as ‘dealing with anger’, ‘how to cope with never having complete resolution’ and my favourite, ‘My Wish List’. This sums up in a nutshell what those of us wish for in a more understanding world, such as ‘I wish you would not be afraid to speak my loved one’s name’. They lived and were important and I need to hear their name’. It may seem inconsequential, but to have someone put in writing what we feel, to say that we are not being unreasonable, actually allows us to feel more able to make allowances when people do not react as we wish.

I needed a long period of time, over two years, in which to learn to feel comfortable feeling good about myself, to give myself permission to enjoy my life again, to accept the changed me and value who this journey has made me, and to learn to love life again. People who were supportive in the weeks after my daughter’s death, soon tired of being understanding and thought I should have moved on. On the second anniversary of her death a work colleague told me it was time I let my daughter go. Obviously, he had no idea what he was talking about, as no one who has experienced suicide would suggest such a thing. At this time, when everyone has moved on, when your grief is old news to them, yet is still new to you, the Support Group is critical in providing a safe environment in which to share stories about your loved one. As a single mother, who had lost her only child, who now faced coming home to an empty house, who lost friends as they did not know how to cope with such a painful loss, the friendships I developed at the Support Group were life-line. I do not believe my healing would have occurred in the same time span, and I am certain the journey to this point would have been more painful, without the Support After Suicide Group.

It has now been 3 years since my daughter’s death. The Support Group has given me the structure and skills to move forward with my life. I consider the group part of my extended family and feel privileged to have met such courageous people. Suicide is such a devastating act, so it is good that something positive can come out of such a negative experience. For more than two years the group has provided me with love, encouragement, hope, friendship, courage and the best counselling available.

The SASG has gratefully received a donation in loving memory of Hartley North who died 10th June, 2007

Book Project

My name is Sandra Russell and on March 5, 2004 my son Drew died through suicide. He was 18 years old and a twin.

One thing I have found since I lost Drew is that my grief journey has been helped by reading other survivors stories or talking to parents that have lost their child through suicide.

I have read books that have been about losing parents, partners, friends and children, but I have not come across one that is solely about losing your child, so I am in the process of gathering stories from parents about their journey since they have lost their child.

I would very much like to hear from parents that have lost children at all ages and not just youth suicide.

I am also very interested in hearing from parents that have lost a child that was a twin like myself, as I do not know anyone that has lost a twin.

All proceeds from the book after expenses, will be given to the Support After Suicide Group at DOPM for their ongoing counselling they give to people surviving suicide. I have an editor who is willing to do the book at no charge to support SASG.

My contact details are

Sandra Russell
“Edmond locality”
Lindfield NSW 2070
Phone 02 6567 5050

** If you do not wish to continue receiving this newsletter, please send a note to the coordinator at the address noted on the front page or alternatively email: kathryn.landef@email.onsw.gov.au **
The SASG has gratefully received a donation in loving memory of
Darren Crookes
who died in 2002, aged 26

Some other Support Groups
Sutherland Shire Support After Suicide Group
3rd Tuesday of the month at 7:00 pm.
Sutherland United Services Club, East Parade,
Sutherland.
The next meetings: 18th Nov and 16th Dec, 2008
Coordinator: Kate van Buren
Phone: 0412 523 140

Lifeline
A number of suicide bereavement support groups are operating through Lifeline with trained volunteers.
Port Macquarie
This support group operates fortnightly (excepting school holidays) in the early evening.
Contact Lee Anne Ford for further information.
Ph: (02) 6581 2800

Mascot
This group operates monthly in the evenings.
Contact Margaret Appleyard for further information.
Ph: 0419 892 273

The SASG has gratefully received a donation from
Quota International of Sydney

SAS Newsletter by Email!
The SAS newsletter is now available electronically, using
PDF format & requiring Acrobat Reader.
If you would like to receive the newsletter through this
means instead of the regular mail, please let me know.
Just send an email request with both your email details
and postage details to
kathy.mead@email.cis.nsw.gov.au

Disclaimer
The information in this newsletter can only assist you in the
most general way. If you need specific advice, please seek an
appropriate professional who is knowledgeable in this area.
Your local GP is often a good place to start.
The contents of this newsletter should not be reproduced with-
out permission.

Kathy’s Column

Readers’ Contributions:
Many readers have fed back to us how helpful they have found reading other people’s contributions. Some of you have sent in poems, quotes and articles that we have been able to use. We would like to encourage you to contribute in this way to the newsletter. If you find a book that you have found helpful, please write a few lines about it and send the details to us. Similarly with poems and articles. It is necessary to have all the details (author, publisher etc) before we can use it but these contributions are highly valuable.

Similarly, if you are able to express your own experiences in writing, this can be very helpful to others. Before accepting and publishing any personal material, we would need your written permission. We always remove any identifying material and sometimes need to edit due to space and other considerations. Any changes made would only be published with your approval.

We are pleased to be able to republish a very moving account of one person’s loss in this newsletter. We are very grateful for the trust they have shown in sharing their experiences. We would ask that you respect their privacy and not reprint/publish this personal account without first contacting us to request their approval.

December’s meeting
As usual, December’s meeting will be shorter than normal and will conclude with time to share over some nibbles and drinks. If you haven’t been for a while you may like to take this opportunity to catch up with old friends. If you are planning to be there, could you let me know? It will help to ensure there is enough food to go round. Just leave a message for me on:
8584 7800
Or email me at
Kathy.mead@email.cis.nsw.gov.au
If you can only make a last minute decision to be there—still come anyway. There will always be enough for you.

Please note, there is
NO January meeting of the SASG

Wishing you a peaceful and safe Christmas season

Kathy
Appendix 14
Information about the Coronial Processes: Example from a Service in Queensland
Used with the kind permission of Standby (Suicide Bereavement) Response Service

CORONIAL FLOWCHART
FOLLOWING SUICIDE DEATH

POLICE
Attend scene
Conduct initial investigation re circumstances of death
Collect initial information from family, friends & witnesses
Inform family of the death,
Investigate and report to Coroner

MORTUARY
Relative or friend may be asked to identify deceased.
Conduct a post mortem (autopsy)

FUNERAL DIRECTOR
Body released for burial or cremation
Organises funeral service at bereaved’s

CORONER
Investigates cause of death
Makes a legal finding on the nature and cause of any sudden death by inquiry or inquest
Details findings in a report and copy sent to family and by request, others with kinship interests

An inquiry is based on police and post-mortem reports (6 months).
An inquest is a court hearing with witnesses (18+ months)
Coroner makes a decision on whether to hold an inquest.
Families can also request the Coroner to hold an inquest.
Coronial Investigations

Magistrates Court – Coroners Court

Once a death is reported, the coroner must investigate the circumstances of the death to establish:

• the identity of the deceased
• when and where they died
• how the death occurred
• what caused the death.

The coroner controls and coordinates each step of the investigation. Police officers usually assist the coroner to gather evidence.

A coronial investigation may take several months. The length of the investigation will depend on the unique circumstances of the case.

The steps of a coronial investigation

1. The death is reported to the coroner, usually by police
2. Police will collect some initial information about the circumstances of the death from family members, friends and witnesses
3. A relative or friend who knows the deceased may be asked to identify the deceased at the mortuary. Sometimes identification will be made by clothing or possessions, or in a small number of cases, through DNA testing.
4. After looking at the initial information the coroner may ask for more details to be provided. For example, the coroner may require the police to obtain medical records or further statements from witnesses.
5. In most cases, the coroner will order an autopsy to help determine the cause of death. Family and cultural concerns are considered before ordering an internal autopsy.
6. Once the autopsy is complete and the coroner is satisfied with the information, the body is released for burial or cremation.
7. The coroner may then use wide powers of investigation and request additional reports, statements or information. This additional information may be gained from investigators, police, doctors, engineers, workplace health and safety inspectors, mining inspectors, air safety officers, electrical inspectors or other witnesses.
8. The coroner will make a decision on whether to hold an inquest into the death. Families can also request the coroner to hold an inquest.
9. The coroner will detail the findings in a report at the end of the investigation and a copy will be sent to the family. If an inquest is held, the findings may be very lengthy.


Information for this document has been adapted from The Dr. Edward Koch Foundation ‘You are Not Alone’ StandBy Response Service Indigenous brochure (© Dr. Edward Koch Foundation 2007), developed in partnership between The Dr. Edward Koch Foundation and the Yarrabah community.
Appendix 15
Example Format of a Supervision Session

Initial session: The supervisor will begin discussion to get to know the facilitator/s and work on the group dynamic (if group supervision) and developing a safe/confidential relationship with the supervisor.

Time will be allowed for facilitator/s to identify any concerns or challenges prior to starting their initial SBSG. The supervisor will facilitate discussion to workshop strategies and ideas as needed.

Guidelines for supervision will also be discussed, including confidentiality. Practical details such as times of supervision and contact details will be attended to. Facilitators will be invited to identify their needs to be addressed in supervision over the coming weeks.

Each subsequent session will have a framework, which will change according to each facilitator’s needs, but would usually incorporate:

• Brief hello/checking in
• Facilitator/s invited to briefly identify how the last SGS group was for them
• Specific issues arising from the group will be addressed in a facilitated discussion
• Opportunity to ask questions/discuss strategies for dealing with issues
• Discussion of, or referral to, any relevant literature will be facilitated as needed
• Opportunity for facilitator/s to identify any issues not dealt with and strategy to deal with issue discussed or referred
• Close and ensure safe disengagement from process.

The final session will incorporate a ‘debrief’ of the supervision experience and discussion of ‘where to from here’ and any closing issues.
Appendix 16
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Appendix 17
Towards Good Practice: Standards & Guidelines for Suicide Bereavement Support Groups

TOWARDS GOOD PRACTICE:
Standards and Guidelines for Suicide Bereavement Support Groups

March 2009
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Introduction

These Standards and Guidelines have been developed as part of the Commonwealth funded SBSG Standards and Best Practice Project. They have been developed in consultation with a broad cross section of suicide bereavement service providers and those bereaved by suicide.

There are four major Standards articulated below with various sub headings:

1. Support group establishment and maintenance
2. Support group philosophy and processes
3. Support group facilitation and management
4. Support group services

This set of Standards and Guidelines has been developed to support those who participate in and those who operate Suicide Bereavement Support Groups. The Practice Handbook also developed under this Commonwealth project, provides more information and examples relevant to facilitating a Suicide Bereavement Support Group.

These Standards and Guidelines provide a voluntary Code of Conduct to assist in the development and review of quality, safety and effectiveness. When developing or reviewing services, these Standards can provide a useful benchmark against which Suicide Bereavement Support Groups can be examined, improved and validated.

While these Standards were developed specifically for use by Suicide Bereavement Support Groups they could also guide practice in other support group settings or other suicide bereavement services.
1. **Support group establishment and maintenance**

### 1.1 Aims and objectives

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<tr>
<td>A statement of the support group’s aims and objectives is made available publicly.</td>
<td>The statement includes the purpose and vision of the support group. Consideration for inclusion in the purpose might be outcomes such as managing emotions, thoughts and behaviours, adjustment, integration, sharing experiences, strategies to cope with daily and significant events, managing interactions with family, friends and colleagues, connection, normalisation, and/or social support, etc. Considerations for inclusion in the objectives are: - the safety principle “Above all, do no harm” - sensitivity - confidentiality - respect, etc.</td>
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### 1.2 Access and membership

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<tr>
<td>People bereaved by suicide are able to access support through the support group when they need it and when they are in a position to benefit from the support group.</td>
<td>Any membership conditions set are clearly articulated, such as: - age - gender - type of relationship with the person who has died - length of time since loss. The entry process to the support group is clearly articulated. Applicants are advised of possible outcomes of the entry process including referral to other services. Applicants are advised about the support group format, such as length of support group program and length of sessions. The support group targets either adults or children/adolescents. This is because the grieving process for children may take different pathways. Assessment of potential members is undertaken by the facilitator of the support group to ensure that people will benefit from the support group. Group members are informed of this process and understand its necessity. Assessment is undertaken either face-to-face or by telephone with the aim of checking that the potential member will be able to benefit from the support group and will not cause harm to themselves or to other members. Some persons bereaved by suicide may be channelled to other more appropriate services (refer Standard 4.4 Referral Services below). Assessment processes are culturally appropriate. Members are able to access venues/technology as needed to participate. Physical meeting space is easily accessible for members. Where required, members have availability and guidance on use of technology for participation. Meeting space is neutral, safe, comfortable, inviting and private. Meeting space has a withdrawal area if possible.</td>
</tr>
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</table>
### 1.3 Organisational and management structure

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<tr>
<td>The support group has a defined organisational structure which allows it to operate.</td>
<td>The support group is either an organisation itself, e.g., an incorporated association, or is auspiced by an organisation. This is to provide a form of governance, risk management and accountability.</td>
</tr>
<tr>
<td>Roles and responsibilities of key personnel are defined.</td>
<td>Key personnel and their responsibilities are defined, including the support group facilitators, co-facilitators, management team and administrative assistance. Job description or role statements are provided to all paid and volunteer personnel.</td>
</tr>
<tr>
<td>Key personnel are qualified to take on their roles.</td>
<td>Key personnel have the required skills and training for their role. Where support group facilitators have been bereaved by suicide, they are sufficiently integrated with their own bereavement to facilitate suicide bereavement support groups.</td>
</tr>
<tr>
<td>The number of support group facilitators and their characteristics accommodate the size and nature of the support group.</td>
<td>A minimum of two group facilitators for each support group is maintained to assist with self-care, peer review (refer Standard 1.5), and demands of the role (refer Standards 3.1 and 3.4). Consideration is given to the number of support group facilitators required for the size and nature of the support group. A ratio of facilitators to support group members is applied for groups of 10 members or more. Consideration is given, where possible, of inclusion of different gender group facilitators to provide an appropriate role model for group members and possible group members. Consideration is given, where possible, of inclusion of Aboriginal or culturally and linguistically diverse (CALD) group facilitators for groups with Aboriginal or CALD members (refer also Standard 3.1).</td>
</tr>
<tr>
<td>The way in which the support group will operate is defined.</td>
<td>Whether the support group is open and ongoing or whether it is time-limited and closed for a specific period is identified and potential members advised accordingly.</td>
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### 1.4 Ethics

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| Codes of Ethics are developed and adhered to by support group facilitators and members. | A written Code of Ethics for support group facilitators is adopted which addresses factors such as:  
- confidentiality and privacy  
- relationships with support group members  
- training in techniques used  
- adoption of organisational/support group policy and procedures/protocols  
- conflict resolution  
- personal gain or conflicts of interest  
- commitment to cultural safety  
- commitment to self-care  
- duty of care, including the “Above all, do no harm” principle (refer also to Standard 4.5).  
Group guidelines or ground rules for support group members are developed, adopted and available which address factors such as:  
- confidentiality  
- acceptance and non-judgement  
- sharing of experiences  
- respect and empathy  
- differences of views and opinions  
- networking amongst group members outside of meetings (refer standard 4.2)  
- time out during sessions  
- exiting the support group.  
Consequences for not adhering to the Code of Ethics are clear and processes for managing such situations are included in the organisation's/support group's protocols. |
| The support group will identify and meet legislative requirements. | Legislative requirements are identified and processes to ensure adherence are established.  
Support group facilitators are aware of legal requirements and incorporate these into their practices.  
Attention to child protection requirements and working with young people security checks may be a requirement for support groups providing services to children or young people. |
### 1.5 Legislative and management requirements

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<tbody>
<tr>
<td>Regular supervision of group facilitation practice and debriefing of support group facilitators is provided by suitably qualified and experienced personnel.</td>
<td>Support for support group facilitators in the form of supervision of group facilitation practice and debriefing is provided. Supervision is a process of care and support delivered by a trained supervisor for facilitators running SBSGs. This may be delivered through a facilitator reference group, the organisational structure, or even through external support arrangements. Group facilitation practice supervision may be in the form of expert supervisors or through processes such as peer coaching or mentoring, depending on the situation and needs of the group facilitators and the requirements of the organisation. These services may be internally or externally sourced, delivered face-to-face, via telephone or on-line. Self-care considerations are made as part of the supervision and debriefing processes.</td>
</tr>
<tr>
<td>Regular administrative supervision is provided.</td>
<td>Administrative supervision is provided by the organisation or the auspicing organisation as part of the operational arrangements.</td>
</tr>
<tr>
<td>Risks are identified and minimised through planning.</td>
<td>Risks considered include but are not limited to:&lt;br&gt;• Accident and injury – public liability cover is in place&lt;br&gt;• Advice and harm – professional indemnity cover is in place&lt;br&gt;• Unsuitability of support group for some members or potential members – referral protocols to other services will be required&lt;br&gt;• Emergency situations – a crisis protocol is in place for potential emergencies including suicide or potential suicide or crises in the group or crisis in the group facilitators(s)&lt;br&gt;• Re-traumatising group members – group management practices are in place to reduce the likelihood of such occurrences&lt;br&gt;• ‘Burn out’ of support group facilitators – access to debriefing and supervision; co-facilitators may be needed or time away from support group management role may be needed&lt;br&gt;• Conflict between members or facilitators – effective conflict resolution processes included in Code of Ethics&lt;br&gt;• Media requests – Media guidelines that clarify media release and spokesperson protocols&lt;br&gt;• Quality assurance of group facilitation sessions.</td>
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## 1.6 Marketing and promotion

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<tbody>
<tr>
<td>Support groups are promoted through relevant agencies so people bereaved by suicide are aware of the existence of the suicide bereavement support group.</td>
<td>The support group is known about by services which come into contact with people bereaved by suicide such as police, coroner, hospitals, general practitioners, allied health providers (psychologists, counsellors, social workers, etc), Aboriginal health services, churches and religious organisations, funeral directors, and community organisations. Support groups consider subscription to central information sources, such as relevant government agencies and community databases which give contact details to the public. Other promotion activities might include advertising through community avenues and/or in local newspapers. Further, a website for or links to the support group may be considered so that potential group members can easily find services. Marketing initiatives meet the Australian Government <em>Mindframe</em> National Media Initiative.</td>
</tr>
<tr>
<td>Marketing and promotion materials are culturally appropriate and are understandable by the whole community.</td>
<td>Information provided on the support group is written or presented in plain English at a level that the community will understand (approximately a level of 6th Grade). Where information is translated, it is written or presented at an appropriate level of understanding. Information is culturally appropriate and collaboration with relevant cultural groups is in place where needed. Marketing and promotion materials show sensitivity to the issues faced by people bereaved by suicide. Materials that are provided on the internet are culturally appropriate and show sensitivity to the issues faced by people bereaved by suicide.</td>
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</table>
2. Support group philosophy and processes

2.1 Philosophy on clients

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<tr>
<td>Values and principles that the support group holds are identified.</td>
<td>The support group clearly articulates the values and principles that they uphold, e.g., Rights of People Bereaved by Suicide (see Appendix 1 of Practice Handbook)</td>
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2.2 Service delivery

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<tr>
<td>Service delivery is client-centred.</td>
<td>Service delivery principles are defined, such as timeliness of service, quality of service, support group topics, closing support group meetings, mode of service delivery including services provided in between group meetings and at the end of the group service. Support group members understand and agree to the group guidelines (refer Standard 1.4).</td>
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2.3 Inclusiveness

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<tr>
<td>A diverse range of people, regardless of background and cultural diversity, are encouraged to participate in suicide bereavement support groups when needed.</td>
<td>Support groups recognise individuality and have strategies in place to include people from different cultural backgrounds, both genders, those less likely to seek help, and those with differences in coping styles and circumstances. Support group facilitators change their group processes to meet client needs. Refer Standard 3.1 Roles of Support Group Facilitators regarding representatives from Aboriginal or CALD backgrounds. Practical support may also need to be given where resources are available, such as child care for evening meetings, or use of an interpreter where language is a barrier. Whether the group member can bring a support person to a support group meeting and the degree of involvement in the group meeting by the support person is articulated.</td>
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### 2.4 Group processes

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<tbody>
<tr>
<td>Where a psycho-educational model is used, group processes include both psychological support and information about aspects such as psychological processes, practical needs, and coping strategies.</td>
<td>Meetings use group processes where psychological support is provided and education on relevant issues is undertaken.</td>
</tr>
<tr>
<td>Resources providing information are available or identified (in the case of the internet).</td>
<td>Information may include literature available from related organisations, information on local services, and relevant activities. Such information is checked for sensitivity, for cultural appropriateness and for readability (plain English).</td>
</tr>
<tr>
<td>Where a self-help model is used, it includes group processes that provide for emotional support.</td>
<td>Group processes at meetings are structured to provide opportunities for airing effects of loss and trauma, for sharing coping strategies, and for a positive closing.</td>
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### 2.5 Understanding of suicide bereavement, loss and trauma

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</table>
| Information about issues that arise for people bereaved by suicide is available and is culturally appropriate. | Access to literature and resources about issues faced by people bereaved by suicide which may include but is not limited to:  
  - general grief and loss theory  
  - trauma  
  - individuality of grief  
  - cultural differences in loss and grief  
  - age and gender differences in loss and grief  
  - statistics about suicide and suicide bereavement  
  - cognitive restrictions of suicidal thinking  
  - stigma (psychosocial, legal and religious) and isolation  
  - feelings of rejection, abandonment and blame  
  - feelings of remorse, guilt and responsibility  
  - feelings of anger and/or helplessness  
  - the need to understand why and the search for motive  
  - difficulty acknowledging the cause of death  
  - fear of hereditary susceptibility  
  - family dynamics  
  - loss of basic trust  
  - increased risk of suicidal ideation  
  - logistical and legal issues  
  - the therapeutic process of hope  
  - acknowledgement of strengths  
  - resilience and integration  
  - potential for growth  
  - coping strategies and interpersonal tactics.  
  Literature and resources are available in various communication media (e.g. video, DVD, tape, etc). |
## 2.6 Support group facilitation models

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</table>
| Support group facilitators use clearly defined facilitation models which are culturally appropriate and promote healing and integration. | Support group facilitators are trained in all facilitation models used.  
The facilitation model(s) incorporate(s) a communication style which promotes group interaction in a safe way and facilitates group processes.  
Support group facilitators’ practices adhere to the facilitation models used. |
### 3. Support group facilitation and management

#### 3.1 Roles of support group facilitators

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<tbody>
<tr>
<td>The roles of the support group facilitators are clearly defined. Consideration of co-facilitation is made with involvement by both professionals (such as counsellors and social workers) and people bereaved by suicide. Where professionals are not involved as support group co-facilitators, access to professional support is available.</td>
<td>Roles include, but are not limited to:</td>
</tr>
<tr>
<td>• pre-assessment of potential group members</td>
<td>• adhering to the Code of Ethics (refer Standard 1.4)</td>
</tr>
<tr>
<td>• using referral processes for potential members not ready for group involvement</td>
<td>• ensuring members know about the group guidelines (refer Standard 1.4)</td>
</tr>
<tr>
<td>• planning and designing support group processes</td>
<td>• ensuring members know about 24 hour contact supports</td>
</tr>
<tr>
<td>• facilitating support group processes and support group dynamics</td>
<td>• ensuring new members feel comfortable and safe</td>
</tr>
<tr>
<td>• adhering to the ‘Above all, do no harm’ principle</td>
<td>• providing direction in structured information sessions</td>
</tr>
<tr>
<td>• ensuring cultural safety</td>
<td>• adhering to the ‘Above all, do no harm’ principle</td>
</tr>
<tr>
<td>• mentoring emerging facilitators</td>
<td>• ensuring cultural safety</td>
</tr>
<tr>
<td>• debriefing co-facilitators</td>
<td>• ensuring cultural safety</td>
</tr>
<tr>
<td>• managing self-care</td>
<td>• ensuring cultural safety</td>
</tr>
<tr>
<td>• developing exit strategies for facilitators leaving the support group</td>
<td>• ensuring cultural safety</td>
</tr>
<tr>
<td>• monitoring and responding to potential suicide risk of members.</td>
<td>• ensuring cultural safety</td>
</tr>
<tr>
<td>The support group has considered the need for involvement by mental health professionals (e.g., psychologists, grief counsellors) and/or by people bereaved by suicide. Co-facilitation of support groups by Aboriginal representatives may be appropriate for groups with Aboriginal people. Likewise with CALD facilitators and CALD members</td>
<td></td>
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3.2 Skills and behaviours of support group facilitators

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</table>
| Support group facilitators exhibit skills and behaviours that provide a supportive environment. | Support group facilitators have basic communication and interpersonal skills, including:  
• ability to organise  
• ability to empathise  
• ability to listen reflectively  
• effective verbal communication skills.  
Support groups have defined the behaviours and attitudes that are expected in their support group facilitators such as, but not limited to:  
• respect  
• compassion  
• trustworthiness  
• openness  
• a non-judgemental attitude  
• retain confidences  
• honesty  
• an approachable disposition  
• cultural considerations  
• gender considerations  
• age relevant considerations  
• minimisation of expression of their own personal grief  
• recognition of their own limitations, etc. |

3.3 Training of support group facilitators

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</table>
| Support group facilitators are trained in basic facilitation models, communication skills, suicide bereavement, grief, loss and trauma and psycho-educational support group processes. | Support group facilitators are trained in aspects such as but not limited to:  
• the experience of loss and grief  
• specific issues of suicide grief  
• complications of grief  
• role of trauma  
• mental health first aid  
• methods for assessing support group applicants  
• group facilitation techniques  
• eliciting skills versus lecturing skills  
• strategies for increasing coping  
• support group management skills  
• the distinction between process and content  
• methods to bring balance to group processes  
• assertiveness skills  
• cultural safety practices  
• strategies to overcome issues and barriers  
• complexity of suicide  
• suicide prevention techniques  
• crisis intervention processes  
• health promotional approach to adversity including the awareness and value of community capacity building  
• Client centred, strengths based approach  
• pathways to care and referral to other services  
• strategies for self-care. |
<table>
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<tbody>
<tr>
<td>Where support groups provide services to children, support group facilitators are trained in child and adolescent suicide bereavement, grief, loss and trauma.</td>
<td>Support group facilitators are trained in aspects such as but not limited to:</td>
</tr>
<tr>
<td></td>
<td>• grief and loss for children and adolescents</td>
</tr>
<tr>
<td></td>
<td>• age appropriate support.</td>
</tr>
<tr>
<td>Support group facilitators undertake professional development on an ongoing basis.</td>
<td>Support group facilitators take an active role in networks and associations that provide continuing professional development opportunities.</td>
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### 3.4 Support group co-facilitation

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<tbody>
<tr>
<td>Where there are co-facilitators, facilitation roles are clearly defined between the co-facilitators. Transition between group facilitators is planned.</td>
<td>Co-facilitators know their roles and the specific tasks for which they are responsible, for example, co-facilitators may allow one facilitator to focus on those group members who are newly bereaved and the other facilitator to focus on those who are long-term bereaved. Support group members are advised of the roles of the co-facilitators. Where group facilitators change or additional facilitators are introduced, group members are prepared in advance of new facilitators to the support group.</td>
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</table>
## 4. Support group services

### 4.1 Meetings

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<tbody>
<tr>
<td>Meetings are well managed to achieve desired goals, articulated in line with the group's purpose and aims (refer Standard 1.1).</td>
<td>Meetings are planned and the structure and frequency of meetings is decided upon in advance.</td>
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<tr>
<td></td>
<td>The venue for meetings is appropriate. For open support groups, the time of meeting and venue is fixed for a period so that potential members who hold onto information about the group for a long time can access the group.</td>
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<td></td>
<td>The structure allows support group members to express their feelings, thoughts and behaviours, and explore their needs. Cultural safety is practised.</td>
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<tr>
<td></td>
<td>Support group facilitators put in place actions for issues that arise in meetings that require follow-up between meetings, particularly where a Duty of Care arises (refer Standard 4.5).</td>
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<tr>
<td></td>
<td>Where appropriate (e.g., closed group format), follow up actions are in place for people who miss meetings or who discontinue. Where this happens, members are advised in advance of this practice.</td>
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### 4.2 Information and networking

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<tbody>
<tr>
<td>Information about suicide bereavement, loss, grief and trauma and people bereaved by suicide is managed to ensure ease of access, appropriateness and that information is reviewed.</td>
<td>Following an enquiry for information by a new member, an information pack is made available, with particular reference to the material of most relevance — may include websites rather than hardcopy.</td>
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<td></td>
<td>Exchange of information among members is encouraged and supported by the support group facilitator(s).</td>
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<tr>
<td></td>
<td>Access to resources is managed so that members can obtain information as required and which is appropriate. Information for the family/social network of the group member is also available.</td>
</tr>
<tr>
<td></td>
<td>Information for children and young people is age appropriate.</td>
</tr>
<tr>
<td>Networking amongst group members is encouraged.</td>
<td>Networking amongst group members is a voluntary choice for the individual. Group members are encouraged to network and connect with other members outside of the group, although this is not a mandatory requirement.</td>
</tr>
<tr>
<td></td>
<td>Group guidelines or ground rules cover networking amongst group members (refer Standard 1.4).</td>
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4.3 **Range of services**

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<tbody>
<tr>
<td>Individuals have different needs and services are flexible and adaptable to meet differing needs.</td>
<td>Services can respond to individual needs. Referral protocols are in place with other support services in the community such as counsellors and other services (refer Standard 4.4 below). Support groups have considered requirements for services between meetings and provide information for members on ways to obtain support between meetings. Where a group operates with a closed format (i.e. finishes after a certain number of meetings), members are prepared for the close of the group and are provided referrals as necessary. Strategies for members exiting the group are in place to ensure that constructive group dynamics are maintained. Recognition is made of an individual's needs and timeliness for progressing to other stages of the bereavement process where the support group is no longer needed.</td>
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4.4 **Referral services**

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| The support group has a network of relevant services to which it can refer persons as necessary. | A list/database of relevant and up-to-date services in the local community is easily accessible and is used as necessary. Services might include, but are not limited to:  
  - Coroner’s office  
  - medical practitioners  
  - hospitals  
  - housing services  
  - financial management services  
  - funeral services  
  - legal services  
  - translation services  
  - 24 hour crisis services  
  - telephone counselling services  
  - grief counselling services  
  - clinical psychological services  
  - mental health services  
  - mental health community teams  
  - suicide prevention services. |

4.5 **Duty of care**

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<tbody>
<tr>
<td>The support group has processes for proactive monitoring of risk for mental health illness or suicide warning signs.</td>
<td>Support group facilitators review the risks and recognise suicide warning signs or signs of mental health issues in members and take active steps to promote the member's safety by linking them with further help. Appropriate codes of ethics and protocols are in place (refer Standards 1.4 and 1.5). Support group facilitators are sensitive to unresolved issues that may arise for members and provide appropriate follow-up and referral (see Standards 4.1 and 4.4) as needed.</td>
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### 4.6 Use of alternate delivery modes

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| Where deemed appropriate, support groups are made available through alternate delivery modes (e.g. telephone or online). | Facilitation of support groups through alternate delivery modes undertake additional measures such as but not limited to:  
  • ensuring that the potential group member has the right to or authority to use the telephone number through which the service will be provided  
  • encouraging group members to have a private and safe location to participate in the telephone support group  
  • giving consideration to time zone differences  
  • e-mailing or posting written information for members in advance  
  • developing additional support group ground rules to overcome non-verbal communication barriers  
  • using facilitation techniques to ensure involvement of all members  
  • managing the size of the group — a smaller group as compared to face-to-face support groups may be required to address the complexities of managing a group by telephone.  
  Safeguards due to ethical considerations are put in place to ensure that communications are interpreted correctly.  
  To apply the ‘Above all, do no harm’ principle, groups are closed and potential members are invited from a referral source or registration process. Utilization of a suitable moderator may also be considered. |

### 4.7 Review and evaluation of services

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| The support group reviews and evaluates its services regularly. | Support group facilitator(s) adopt self-evaluation and continuous improvement practices, perhaps in conjunction with supervision (refer Standard 1.5). Group facilitators conduct evaluations of their services delivered and meetings facilitated.  
  At least an annual review of services provided is undertaken. Where possible, consideration is given to an external review on a regular basis to provide an increased level of objectivity.  
  Where members are involved in reviews and evaluations, they are informed in advance of any requests for their feedback. |
Project Partners: